Cigna Member Website

www.Cigna.com

You can access practically every tool, feature and program that Cigna has right from your secure myCigna® account. From programs that help improve your health to tools that help manage your health spending, there's so much you can do.

Get to know the full value of myCigna®:

- ☐ View, print and send ID cards
- ☐ Find in-network doctors, hospitals and medical services
- ☐ Compare quality of care information, including patient reviews from Cigna Healthcare℠ customers
- ☐ Manage and track claims
- ☐ See cost estimates for medical procedures
- ☐ Use the click-to-chat feature to connect with a live Cigna Healthcare rep

How To Register For The First Time:

Step 1 – Navigate to the Website

- Go to www.cigna.com
- Click "Register" under "Haven't created an account yet?"
- Be sure to have your Social Security number or Cigna ID number ready
- Click "Start Registration" at the bottom of the page.

Step 2 – Create an Account

- Complete all fields and click "Continue"
- Enter your Social Security number or Cigna ID number and click "Continue"
- Choose a Security Question and Answer and click "Continue"

Step 2 – Create Credentials

- Create a user name
- Create a password

- Continue with remaining fields
- Click “Continue”

Step 3 – Verify your Account

- Enter the code sent to your email address to verify, then click “Verify and Continue”
- Enter and verify your phone number OR click “do it later”
- View your Coverage Summary and click “Continue”
- Enter a Primary Care Provider (PCP), view Cigna’s programs and explore your new myCigna® account

Get the myCigna® App

Download the myCigna® App and log in for easy access to your benefits and Cigna resources.

Find a Doctor

Cigna’s online directory makes it easy to search for an in-network doctor.

- ☐ Step 1: If you’re already a Cigna member, log into myCigna.com or the myCigna® app to search your current plan’s network. If you’re not already a Cigna member, go to Cigna.com and click on “Find a Doctor” at the top of the screen. Then, under “How are you Covered?” select “Employer or School.”
- ☐ Step 2: Change the geographic location to the city/state or zip code you want to search. Select the search type and enter a name, specialty or other search term. Click on one of their suggestions or the magnifying glass icon to see your results.
- ☐ Step 3: Answer any clarifying questions, and then verify where you live.

Cigna One Guide®

Your Cigna One Guide® team is ready to answer all your health plan questions. Understanding and using your health plan isn’t always easy. Your Cigna One Guide® team is ready and waiting to help. It’s their highest level of personal support available.

Simply call them, click-to-chat on myCigna.com or use the myCigna® App. You’ll automatically be connected to a One Guide representative who will help guide you where you need to go. Helping you save money and stay healthy. Your Cigna One Guide® team can help you:

- ☐ Understand your plan
- ☐ Get Care including finding in-network care, connect you with health coaches, and connect you with dedicated one-on-one support for complex health situations
- ☐ Save and Earn by getting cost estimates to avoid surprises

Coverage At A Glance

Below is a snapshot of the Wayne County High-Deductible Health Plan. With this plan, you will need to set up a Health Savings Account (HSA) at the bank of your choice; after you do this, $400(single)/$800(family) will be deposited into this account annually, to be used for your health care needs. Additionally, if you decide to do a little work to either maintain or obtain a healthy lifestyle, you will be able to earn extra dollars as well! In fact, you can earn up to an extra $500 (single)/*$1,000 (family) each year by passing specific health tests! It is the reward for your work and dedication to your health! For more information on this opportunity, please refer to the Tab titled "Consumer Program".

Consumer Driven Health Plan Design

HIGH-DEDUCTIBLE

High-Deductible Plan Design **Cigna Open Access Plus** TYPE OF SERVICE	**High-Ded** IN-NETWORK	**High-Ded** OUT-OF-NETWORK
	single/family	single/family
Annual Deductible	$1,800/$3,600	$1,800/$3,600
Individual Deductible Limit	$3,200	$3,200
Preventative Care	100%	65%
After Annual Deductible	Plan Pays 85% of Covered Charges	Plan Pays 65% of Covered Charges
Annual Out-of-Pocket Maximums	$5,000/$10,000	$10,000/$20,000
Prescription Drugs:		
Preventative	Rx Program	You Pay 100%
Non-Preventative:		
Before Annual Deductible Met	You Pay 100%	You Pay 100%
After Annual Deductible Met	Rx Program	You Pay 100%
After Annual Out-of-Pocket Met	We Pay 100%	You Pay 100%
Cash Contributions To Your HSA Account[1]	$400/$800	
Wellness Incentives Annual Maximum[1]	$500/$1,000*	
*($1,000 family = up to $500 for employee and up to $500 for spouse)		
Total you can earn annually to help offset your deductible	$900/$1,800	

[1]COBRA members are not eligible for this benefit.

This is a short recap of your medical benefits, not your Summary Plan Description. Please see the Summary Plan Description for additional details and terms of your actual coverage. Wellness incentives and cash contributions to HSA accounts are determined annually. Co-pays, Co-insurance limits, Deductibles and Maximum out of pocket amounts indicated are only for covered services.

Updated 1/1/2024

On this page and the next page, you will see a snapshot of the Wayne County plan design. The first chart is the base plan design. If an incentive plan was not offered, these are the rates that everyone would be paying. However, if you decide to do a little work to either maintain or obtain a healthy lifestyle through the Wellness Program, then you will want to look at the chart on the next page (it is the reward for your work and dedication to your health). Keep in mind that without the Wellness Program, the second chart would not be available.

Health First Base Plan Design (Low-Ded Plan)

WITHOUT INCENTIVE

Low-Ded Plan Design **Cigna Open Access Plus** TYPE OF SERVICE	**Low-Ded** **Non-Incentive** IN-NETWORK	**Low-Ded** **Non-Incentive** OUT-OF-NETWORK
	single/family	single/family
Annual Deductible	$1,000/$2,000	$1,500/$3,000
Annual Out Of Pocket Maximum Including Deductible	$3,000/$6,000	$4,500/$9,000
Primary Office Visits	$40 copay then 100%	60% after deductible
Specialist Office Visits	$80 copay then 100%	60% after deductible
Preventative Care	100%	60% after deductible
Lab	$80 copay then 100%	60% after deductible
Radiology (CT, MRI, X-RAY, etc)	70% after deductible	60% after deductible
Inpatient Hospital	70% after deductible	60% after deductible
Outpatient Hospital	70% after deductible	60% after deductible
Emergency Room	$300 copay then 100%	$300 copay then 100%
Health Risk Assessment/ Wellness Participation Required?	No	No
This is a short recap of your medical benefits, not your Summary Plan Description. Please see the Summary Plan Description for additional details and terms of your actual coverage. Incentive rules are determined annually. Co-pays, Co-insurance limits, Deductibles and Maximum out of pocket amounts indicated are only for covered services.		
Updated 10/7/2022		

Health First Base Plan Design (Low-Ded Plan)

WITH INCENTIVE

Requires completion of 5 Wellness Points and Health Risk Assessment by November 15th

Low-Ded Plan Design **Cigna Open Access Plus** TYPE OF SERVICE	**Low-Ded** **+Incentive** IN-NETWORK	**Low-Ded** **+Incentive** OUT-OF-NETWORK
	single/family	single/family
Annual Deductible	$500/$1,000	$1,000/$2,000
Annual Out Of Pocket Maximum Including Deductible	$1,500/$3,000	$3,000/$6,000
Primary Office Visits	$20 copay then 100%	60% after deductible
Specialist Office Visits	$40 copay then 100%	60% after deductible
Preventative Care	100%	60% after deductible
Lab	$40 copay then 100%	60% after deductible
Radiology (CT, MRI, X-RAY, etc)	80% after deductible	60% after deductible
Inpatient Hospital	80% after deductible	60% after deductible
Outpatient Hospital	80% after deductible	60% after deductible
Emergency Room	$150 copay then 100%	$150 copay then 100%
Health Risk Assessment/ Wellness Participation Required?	Yes	Yes
This is a short recap of your medical benefits, not your Summary Plan Description. Please see the Summary Plan Description for additional details and terms of your actual coverage. Incentive rules are determined annually. Co-pays, Co-insurance limits, Deductibles and Maximum out of pocket amounts indicated are only for covered services.		
Updated 10/7/2022		

Attention!

SAVE $$$! If you have services performed at *Wooster Community Hospital*, your coinsurance will be reduced by 5%.

The following sub-groups may or may not provide coverage to spouses. If you are unsure about this, please contact your employer:

- ☐ Apple Creek

Cigna Programs and Resources

Cigna offers many programs and resources to plan members, including:

- ✓ **Virtual Care from MD Live**
- ✓ **Behavioral Health Programs**
- ✓ **Flexible Fitness Program**
- ✓ **Identity Protection**
- ✓ **Health Coaching for Chronic Conditions**
- ✓ **Medicare Option Reviews**

If you have any questions, please call Barb Winey, HR Director, at 330-287-5409 or Misty White, Employee Health Clinic Nurse at 330-287-5487.

HEALTH CARE THAT'S THERE FOR YOU WHEN AND WHERE YOU NEED IT

Head-to-toe virtual care[1] from MDLIVE.®

It's not always easy to find time for the health care you need. After all, doctors' appointments traditionally involve time and travel. That can lead to putting off care until problems become more serious, and potentially more expensive.

That's why Cigna has partnered with MDLIVE to offer a comprehensive suite of convenient virtual care options — available by phone or video whenever it works for you. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of over 10 years of experience, and provide personalized care for hundreds of medical and behavioral health needs.

Now you don't have to wait — or travel — for the care you need.

Connect with video or phone, whenever it's convenient for you. Best of all, virtual care from MDLIVE board-certified doctors is available to you and your eligible dependents as part of your health benefits.

MDLIVE

Primary Care

Preventive care, routine care, and specialist referrals

- Preventive care checkups/wellness screenings available at no additional cost[2] to identify conditions early
- Routine care visits allow you to build a relationship with the same primary care provider (PCP) to help manage conditions
- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work and screenings at local facilities[3]

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists
- Schedule an appointment that works for you
- Option to select the same provider for every session
- Care for issues such as anxiety, stress, life changes, grief and depression

Dermatology[4]

Fast, customized care for skin, hair and nail conditions — no appointment required

- Board-certified dermatologists review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Diagnosis and customized treatment plan, usually within 24 hours

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961333 11/21

Offered by: Cigna Health and Life Insurance Company or its affiliates.

3 easy steps to connect to care

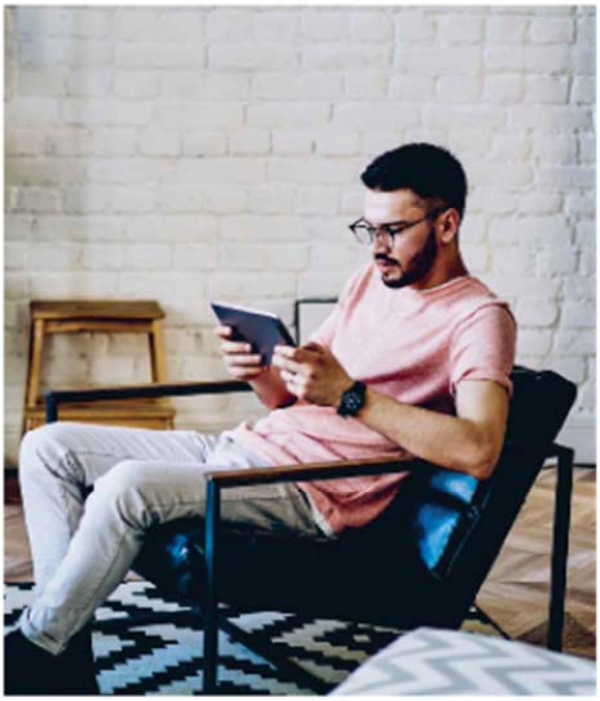
Virtual care visits are convenient and easy.
To schedule an appointment:

Access MDLIVE by logging into myCigna.com and clicking on "Talk to a doctor." You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)

Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE

Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care

Appointments are available via video or phone, whenever it's most convenient for you. Virtual dermatology does not require an appointment.



Visit myCigna.com to make an appointment for virtual care today.

Together, all the way.*

Cigna.

1. Cigna provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. Virtual primary care through MDLIVE is only available for Cigna medical members aged 18 and older.
2. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.
3. Limited to labs contracted with MDLIVE for virtual wellness screenings.
4. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

You're not alone

The Cigna Total Behavioral Health Program can help you move forward.

Studies show that behavioral problems, such as depression, can contribute to heart disease.[1] Many physical conditions can worsen with stress, substance use and other behavioral health issues. Our Cigna Total Behavioral Health® program can help.

Our whole-person approach

If you or a loved one has been diagnosed with a behavioral health condition, we are here for you. Our comprehensive program provides help with life events, dedicated support, lifestyle coaching, and online tools. **You can call us anytime, any day.** We're here 24/7 to assist you with your routine or urgent needs. We can also help you find a provider with confirmed appointment availability.

Virtual behavioral care

You can talk to a licensed psychiatrist or counselor by phone or video with MDLIVE[2,3] or our Behavioral Health network. With MDLIVE you can schedule phone and video appointments online. With our Behavioral Health network, you can find a provider and start video counseling by going to MyCigna.com, Find Care & Costs.

You can also access online therapy through Talkspace,[2] via private messaging or live video session. Refer to your plan documents for costs and details of coverage. We also include Ginger behavioral health coaching via text-based chats, self-guided learning activities and content, and, if needed, video-based therapy and psychiatry.[2,3]

myCigna.com guided navigation

Our digital portal includes guided navigation that provides you with personalized, convenient care options to help you along your journey. Care options include digital, coaching, virtual and in person options.

On-demand coaching and personalized learning with iPrevail offered through Cigna[2]

Learn how to boost your mood and improve mental health with on-demand coaching 24/7. After completing a brief assessment, you receive a program tailored to your needs that includes interactive lessons and tools. You get access to a peer coach who is matched based on your symptoms. You can also join support communities focused on stress, anxiety, depression and more. iPrevail also includes a caregiver support program designed to help you cope with stress, improve resilience and enhance your overall health and well-being.

Services to help manage life events

At no additional charge to you, you can receive face-to-face sessions[4] with a licensed mental health professional in our Employee Assistance Program network.[5] You also get online, on-demand seminars, as well as community resources and referrals on a range of topics, including:

- Child care
- Adoption
- Senior care
- Pet care
- Legal and financial consultation services[6]
- Identity theft support
- Summer camps
- Parenting
- Convenience services

Enhanced ways to access care

We offer provider search and match support, in-the-moment appointment scheduling, and new online scheduling options.[7]

Unlimited in-the-moment consultations

Our team will take time to talk through your issue and get you to the right resource or licensed clinician based on your needs.[7]

100% follow up

After your initial consult, we'll check in with you digitally or telephonically to see if your needs are being met or provide additional assistance if needed.[7]

Science-based activities and games for stress and worries, with Happify offered through Cigna[2]

Everyday stressors can impact your relationships, work, health and emotional well-being. But you can change your outlook — and the way you see the world — with Happify. Happify's activities and games are designed to help you overcome life's challenges and can be accessed at any time.

Behavioral Specialty Coaching & Support Services

Our coaches provide dedicated support for a broad range of conditions including:

- Autism spectrum disorder
- Eating disorders
- Intensive behavioral case management
- Opioid and pain management
- Substance use

We also provide coaching and support for parents and families, which empowers individuals to be effective advocates for their family member or their own mental health needs. Our team can help for as long as needed (you must stay covered under your plan to continue service).

They can help you:

- Understand a behavioral diagnosis
- Learn about treatment choices and how your choices can affect what you'll pay out of pocket
- Identify and manage triggers that affect your condition
- Find a health care professional or facility in our network geared to your needs. Our network includes a Centers of Excellence (COE) program.[8] COE facilities have earned a top ranking for quality and cost-effective care. With nationwide locations for adult mental health, child and adolescent mental health, eating disorder and substance use treatment, help is available and closer than you think.
- Find community resources and programs near you
- Get referrals to other wellness and lifestyle programs available to you

Our Coaching and Support services include a digital interface through Vela.[2] Your Coach will help you acquire the app which features secure two-way messaging, ability to share resources, as well as appointment tracking on a shared calendar.

Take control of your health with extra support.

Lifestyle management programs

Get help to reach your goals like losing weight, quitting tobacco or lowering your stress level. Each program offers support with phone and online coaching.

Behavioral awareness webinars

We offer free monthly seminars on autism, eating disorders, substance use and behavioral health awareness for children and families. The seminars are taught by industry experts and offer tips, tools and helpful information.

Enhanced online tools

Visit **myCigna.com** or use the myCigna® app to access on-demand support, including:

- Information about your benefits, in-network providers and treatment options
- Health and well-being articles
- Self-assessment, stress management and mindfulness podcasts and tools

Additional resources can be found on Cigna.com.

To learn more or access services:

To access services to help manage life events, visit **myCigna.com**, Coverage, Employee Assistance Program.

You can call **877.231.1492** for referrals or go online, search the provider directory and obtain an authorization.

For links to iPrevail and Happify, visit the Wellness page. You can also call the toll-free number on your ID card.

GET HELP WITH CHRONIC CONDITIONS

Your health coach provides the guidance and support you need.

Chronic health conditions don't have to keep you down. Cigna provides one-on-one dedicated health coaching to help you:

- **Manage a chronic health condition,** ranging from asthma and low back pain to depression and coronary artery disease, among many others
- **Make more educated decisions** about your health and treatment options
- **Obtain information and resources** about your condition
- **Save money** on your medically related expenses
- **Create a plan** to help improve your health, based on your personal goals
- **Understand medications** and doctor's orders
- **Identify the triggers** that affect your condition

Online tools help you take charge of your health

24/7 online support helps you better understand your condition and overcome barriers to better health.

- **Online programs** that can offer help with lifestyle issues such as weight management, stress and smoking, and chronic condition support for diabetes, asthma, heart failure and more
- **Tools** to help you understand your condition and make more informed treatment decisions
- **Articles and podcasts** for education on hundreds of important health topics

Together, we can help you take control and achieve your health goals

Take the first step toward taking control of your chronic conditions today. Call us at the number on your Cigna ID card.

Or, visit **myCigna.com** for information and self-help resources.

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IdentityForce.
A TransUnion® Brand

OFFERED THROUGH cigna healthcare

Protecting What Matters Most

Identity theft can have serious repercussions. It can hurt your credit score, taint your medical records and drain your college funds and retirement accounts – everything you've worked so hard to build.

IdentityForce, a TransUnion® brand, has been helping people protect their identity and credit for over 40 years, and our Certified Resolution Specialists work diligently to keep you and your family safe.

Two ways to activate your account[1]

1. Visit https://cigna.identityforce.com/starthere
2. Call 833-580-2523

Questions?

Call Member Services at
1-833-580-2523

[1]Available to employees enrolled in a Cigna Healthcare℠ medical plan and their children in household up to age 18.

Offered by Cigna Health and Life Insurance Company

PLAN FEATURES

Identity Protection

Dark Web Monitoring
Compromised Credentials Alerts
Change of Address Monitoring (USPS)
Court Records Monitoring
Sex Offender Registry Notification
Smart SSN Tracker (SSN Monitoring)
Social Media Identity Monitoring
Medical ID Fraud Protection
Identity Vault and Secure Storage

Credit Health and Financial Account Protection

Bank and Credit Card Activity Alerts
401(k), HSA and Investment Account Activity Alerts
Any Financial Account Covered
Education Resource Center
Credit Score Simulator
Credit Score Tracker (monthly)
Credit Freeze and Lock Assistance (Adult and Child)
Credit Monitoring TransUnion (daily)
Credit Report and Score TransUnion (quarterly)

Restoration Services

24/7 Customer Support
Fully Managed Identity Restoration
Restoration for Pre-Existing Identity Theft
Deceased Member Fraud Remediation[2]
Stolen Funds Replacement
Lost Wallet Assistance
$1M Expense Reimbursement Insurance[3]

Mobile and PC Protection

Mobile App (iOS and Android)
Password Manager

[2]Deceased Household Member Fraud Remediation available for adults or eligible dependents enrolled in an active IdentityForce Family Plan at the time of their death

[3]The expense reimbursement insurance benefit for members is underwritten by certain Underwriters at Lloyd's, under a master group policy issued in the name of Cyberscout Limited, Sontiq Inc. and all subsidiaries for the benefit of members. A summary of the terms of coverage are set forth in your account dashboard under the "Support" tab. The complete policy is available from Sontiq on request. Claims will be reviewed by the insurer in accordance with the terms and conditions of the master group policy. Restoration services are provided by Sontiq, Inc.

The program and services are provided by **Sontiq, Inc. and not by Cigna Healthcare or its affiliates.** Program and services are subject to all applicable program terms and conditions. Product availability may vary by location and plan type and is subject to change. References to third-party organizations or companies, and/or their products, processes or services, does not constitute an endorsement or warranty thereof. Your use of such products, processes or services are at your sole risk. Product may be updated or modified prior to availability.

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ABOUT IDENTITYFORCE

IdentityForce, a TransUnion brand, offers proven identity, privacy and credit security solutions. We combine advanced detection technology, timely alerts, identity recovery and 24/7 support with over 40 years of experience to get the job done. We are trusted by millions of people, global 1000 organizations and the U.S. government to protect what matters most.

Thank you for being a valued customer. We're here to help make sure you're getting care and services that fit your current needs.

Cigna Medicare Concierge Services are provided by licensed benefit advisors who help you sort through your Medicare options. Here's what you can expect:

- Facts about what Medicare does and doesn't cover
- A look into money-saving programs
- Answers to your Medicare questions
- Information about special enrollment periods

Get help to review your Medicare options with a licensed benefit advisor.

1-866-317-4116 (TTY 711)

Monday – Friday,
7:30 a.m. – 7:30 p.m. CT

You may also find answers you need online, 24/7.

CignaMedicare.com

Together, all the way.®

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Summary Plan Description

Wayne County Medical Benefit Plan

Table of Contents

Important Notice

The Wayne County medical benefits plan (Plan) described in this Summary Plan Description (SPD) is a benefit plan of the Employer. These benefits are not insured with Cigna or any of its affiliates, but will be paid from the Employer's funds. Cigna and its affiliates will provide certain administrative services under the Cigna medical benefits plan.

Cigna agrees with the Employer to provide administrative services in accordance with the conditions, rights, and privileges as set forth in this SPD. The Employer selects the products and benefit levels under the Cigna medical benefits plan.

The SPD describes your rights and obligations, what the Cigna medical benefits plan covers, and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this SPD. This SPD includes the Schedule of Benefits and any amendments.

This SPD replaces and supersedes all SPD's describing coverage for the medical benefits plan described in this SPD that you may previously have received. The plan sponsor reserves the right to interpret, amend and/or terminate this plan, in whole or in part, at any time and for any reason.

Employer ..... ***Wayne County***
Contract Number ***3345930***
Plan Network ..... ***Open Access Plus***
Plan Coverage Start Date ..... ***January 1, 2024***

Coverage for You and Your Dependents

Health Expense Coverage

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a health care service or supply. It is your responsibility to notify us if you or your dependents are no longer eligible for coverage under any of the Plans. Employees are responsible to reimburse the Plans for any administrative or claim expenses incurred by the Plan for coverage provided for ineligible members on or after the coverage period has ended.

Coverage under this plan is non-occupational. Only Non-Occupational Injuries and Non-Occupational Illnesses are covered.
Refer to the What the Plan Covers section of the SPD for more information about your coverage.

Treatment Outcomes of Covered Services

Wayne County and Cigna are not providers of health care services and therefore are not responsible for and do not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for CVS Caremark, providers of health care services, including Hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of Cigna or its affiliates.

When Your Coverage Begins

Who Can Be Covered, How and When to Enroll, When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Who Can Be Covered

Elected Officials/Employees

To be covered by this plan, the following requirements must be met:

- ☐ You must be *actively employed* (defined as actively working, using any form of paid leave, or on approved FMLA); and
- ☐ You will need to be in an eligible class, as defined below; and
- ☐ You will need to meet the Eligibility Date criteria described below.
- ☐ You will need to enroll and be accepted for coverage.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- ☐ You are an Elected Official or regular full-time employee, as defined by your employer (for purposes of this SPD, full-time is defined as being expected or determined to be a permanent employee working on average 30 or more hours per week).
- ☐ You do not meet the regulations above, but you meet the regulations to be eligible for insurance under Affordable Care Act (ACA) rules.

Determining When You Become Eligible

You become eligible for the plan on your Eligibility Date, which is determined as follows:

On the Plan Coverage Start Date

If you are in an eligible class and are currently enrolled on the plan coverage start date, then your coverage Eligibility Date is the same as the plan coverage start date and there is no waiting period.

After the Plan Coverage Start Date

If you are hired or enter an eligible class after the plan coverage start date, your Eligibility Date is as follows:

- The first of the month that occurs 1 calendar month *after* the month in which you are hired (this is considered your Administrative Period).
- Example: If your hire date is between January 1 and January 31, 2017, you will start on the Health Plan on March 1, 2017.

Obtaining Coverage for Dependents

Qualified dependents can be covered under this Plan. You may enroll the following dependents:

- ☐ Your Spouse.
- ☐ Your children.

Cigna will rely upon the Plan Administrator to determine whether or not a person meets the definition of a dependent for coverage under this Plan. This determination will be conclusive and binding upon all persons for the purposes of this Plan.

Coverage for Spouses

To be eligible, a Spouse must meet the following definition:

- The marriage is recognized by the State of Ohio as being a legal marriage; and
- You are married and living together as a married couple; or
- You are married and living apart, but not legally separated under a decree of divorce, separate maintenance or legal separation document; or
- You are separated under an interlocutory (not final) decree of divorce.

Married employees cannot be members on separate county insurance plans (unless one of the employees is employed by a noncounty agency that does not allow Spouses on their plan).

Coverage for Eligible Children

To be eligible, a child must be under 26 years of age and qualify as identified below under "An Eligible Child".

An Eligible Child includes:

- Your biological children;
- Your Stepchildren, as long as their parent is included on the insurance plan as a Spouse;
- Your legally adopted children or children placed with you for adoption;
- Any children for whom you (our employee) are responsible under court order.

Coverage for a handicapped child may be continued past the age limits shown above. See "Handicapped Dependent Children" for more information.

Important Notice: In the case of Stepchildren, whether or not the custodial parent is a member on the plan, they should have access to their covered child's medical card with the ability to communicate that information to the child's doctor.

Important Reminder: Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

Please note that you will need to provide proof of your dependent(s)' eligibility (such as a Marriage or Birth Certificate and any court orders) when you originally enroll your dependent(s) and whenever an eligibility audit is conducted.

How and When to Enroll

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by the Plan Administrator. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your Eligibility Date. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify for a Life Event enrollment, as described below.

Late Enrollment

If you do not enroll for coverage when you first become eligible, but wish to do so later, you may request information from your employer on when and how you can enroll.

Annual Enrollment/Open Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. Annual enrollment typically occurs from mid-October to mid-November. The choices you make during this annual enrollment period will become effective on January 1 of the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Life Events, as described below.

Life Event Enrollment

You are not permitted to terminate, add or make changes to a plan or the dependent(s) on a plan at any time other than Open Enrollment, unless you qualify for a Life Event as defined below. You may make changes to your insurance, including your dependent(s) and/or plan options, for a Life Event if you:

- ☐ Are an Eligible Employee in an Eligible Class at the time of the Life Event; and
- ☐ You, or one of your dependents that are on or will be added to/removed from the plan, experience a qualifying Life Event; and
- ☐ You notify your employer and complete an enrollment within 31 days of the event.

Enrollment instructions will be provided by your employer upon request.

The following will be considered as qualifying Life Events and proof may be required as a condition of eligibility and must be supplied upon request:

- ☐ *Marriage.* This plan will allow for the addition or termination of insurance for a marriage, involving you or your child that will be terminating from your plan, that is recognized by the State of Ohio as being a legal marriage and with submission of a certified marriage certificate.

- ☐ *Divorce, Legal Separation or Annulment.* This plan will allow for the addition or termination of insurance for a divorce, legal separation or annulment involving you or your child that will be joining or terminating from your plan and with submission of an applicable certified court certificate.
- ☐ *Death of Spouse or Child*.
- ☐ *Birth, Adoption, or Placement for Adoption.* New children must fit the definition of an Eligible Child and will require submission of a certified birth certificate unless:
    - Birth by a dependent currently covered on the plan is being used as a reason for that dependent to terminate from the Employee's plan; or
    - A new child is placed in your care for adoption and you have taken on the legal obligation for total or partial support of the child and a certified birth certificate is not available and you are able to provide another acceptable form of proof of placement.
- ☐ *Termination of the Employment of Spouse or Child.*
- ☐ *Start of New Employment of Spouse or Child*
- ☐ *Change in Employment Status (between part-time and full-time) by the Employee, Spouse or Child.*
- ☐ *A Strike or Lockout Reducing Hours of Employment of Employee, Spouse or Child*
- ☐ *Start or Return from Unpaid Leave of Absence from Employment by Employee, Spouse or Child*
- ☐ *Significant Change in Health Coverage of Employee, Spouse or Child*
- ☐ *A Change in the Place of Residence or Work of Employee, Spouse or Child, Which Changes that Individual's Plan Service Area*
- ☐ *Child of Employee Becoming Ineligible for Coverage.* This includes a child becoming ineligible due to age limits.
- ☐ *Entitlement to Medicare or Medicaid of Employee, Spouse or Child*
- ☐ *Issuance of a Judgement, Decree or Order That Requires Health Coverage for Employee's Child.* In the case of dependent care benefits under Article VIII, such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code Section 125. Such events will be triggered by the receipt of a National Medical Support Notice (NMSN) that has been issued by a court or a state child support enforcement agency authorized to issue Child Support Orders that provides for the medical support of a child. This plan will provide coverage for a child who is identified on a NMSN, if:
    - The child meets the plan's definition of an eligible dependent; and
    - A state child support enforcement agency issues a NMSN that the group health plan determines to be qualified; and
    - The issuing state child support enforcement agency does not issue a Notice to Employer/Health Plan Administrator of Expiration or Terminations of Withholding Requirements Under the NMSN.

  Coverage for the dependent will become effective on the date of issuance of the medical Child Support Order if received within 31 days of issuance, or as required by the NMSN.
- ☐ *Enrollment of Employee, Spouse or Child in a State or Federal Healthcare Exchange*

Important Notices:

- If you do not report your Life Event and submit all required documentation and your

enrollment is not received within 31 days of the date the Life Event took place, then you will not qualify to make changes to your insurance plan and will need to wait to make changes during the next annual enrollment period.

- You must pay any increase in premiums in full or coverage will not be effective.
- For child(ren) under a NMSN, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims may be paid to the custodial parent.
- All current requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) outlined in the Special Enrollment Notice (behind Tab 10) are covered by the Plan.

When Your Coverage Begins under Life Events

Your Effective Date of Coverage

If you met the requirement of a Life Event and completed all requirements for enrollment within the defined time, then your Effective Date of coverage will take place as follows:

- ☐ On the date that the Life Event took place, if you added insurance or made a change to your plan due to the Life Event.
- ☐ On the last day of the month, if you terminated insurance due to a Life Event.
- ☐ There was no change to your Effective Date of coverage, if you
  - ■ Are only adding or terminating dependent(s) from your plan; and
  - ■ You were previously and will continue to be enrolled on the same plan

Your Dependent's Effective Date of Coverage

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan.

How Your Medical Plan Works

Common Terms, Assessing Providers, Precertification

It is important that you have the information and useful resources to help you get the most out of your medical plan. This SPD is not all inclusive, but explains:

- ☐ Definitions you need to know;
- ☐ How to access care, including procedures you need to follow;
- ☐ What expenses for services and supplies are covered and what limits may apply;
- ☐ What expenses for services and supplies are not covered by the plan;
- ☐ How you share the cost of your covered services and supplies; and
- ☐ Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

Important Notices:

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your health plan pays benefits only for services and supplies described in this SPD as Covered Expenses that are Medically Necessary.
- This SPD applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- Store this SPD in a safe place for future reference.

Common Terms

Many terms throughout this SPD are defined in the Glossary section at the back of this document. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About Your Medical Plan

This medical plan provides coverage for a wide range of medical expenses for the treatment of Illness or Injury. It does not provide benefits for all medical care. The plan also provides coverage for certain preventive and wellness benefits. With your plan, you can directly access any Physician, Hospital or other health care provider (in-network or out-of-network) for covered services and supplies under the plan. The plan pays benefits differently for services and supplies obtained through In-Network Providers versus Out-of-Network Providers.

The plan will pay for Covered Expenses up to the maximum benefits shown in this SPD. Coverage is subject to all the terms, policies and procedures outlined in this SPD. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the What the Plan Covers, Exclusions, Limitations and Schedule of Benefits sections to determine if medical services are covered, excluded or limited.

This plan provides access to covered benefits through a network of health care providers and facilities. These In-Network Providers have contracted with Cigna, an affiliate or third-party vendor to provide health care services and supplies to plan members at a reduced fee called the Negotiated Charge. This plan is designed to lower your out-of-pocket costs when you use In-Network Providers

for Covered Expenses. Your Deductibles, Copayments, and Payment Percentage will generally be lower when you use participating In-Network Providers and facilities.

You also have the choice to access licensed providers, Hospitals and facilities outside the network for covered benefits. Your deductibles, Copayments, and Payment Percentage are usually higher when you utilize Out-of-Network Providers. Also, out-of-network providers have not agreed to accept the Negotiated Charge and may balance bill you for charges over the amount Cigna pays under the plan.

Some services and supplies may only be covered through In-Network Providers. Refer to the What the Plan Covers section and your Schedule of Benefits to determine if any services are limited to in-network coverage only.

Your out-of-pocket costs may vary between in-network and out-of-network benefits. Read your Schedule of Benefits carefully to understand the cost sharing charges applicable to you.

Availability of Providers

Cigna, as the network provider, cannot guarantee the availability or continued participation of a particular provider. Either Cigna or any In-Network Provider may terminate the provider contract or limit the number of patients accepted in a practice. If the provider you select is not available for new patients, then Cigna has a list of In-Network Providers and services which can be accessed by logging into your Cigna account.

Ongoing Reviews

Cigna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits under this SPD. If Cigna determines that the recommended services or supplies are not covered benefits, you should be notified. You may appeal such determinations by contacting Cigna to seek a review of the determination. Please refer to the Reporting of Claims and the Claims and Appeals sections of this SPD.

To better understand the choices that you have with your Cigna Open Access Plus plan, please carefully review the following information.

How Your Medical Plan Works

The Primary Care Physician

To access in-network benefits, you are encouraged to select a Primary Care Physician (PCP) from Cigna's network of providers at the time of enrollment. Each covered family member may select his or her own PCP. If your covered dependent is a minor, or otherwise incapable of selecting a PCP, you should select a PCP on their behalf. By choosing a PCP, you will have one medical professional helping you navigate all of your healthcare needs. A PCP coordinates your medical care, as appropriate either by providing treatment or may direct you to other In-Network Providers for other covered services and supplies. The PCP can also order lab tests and x-rays, prescribe medicines or therapies, and arrange Hospitalization. Selection of a PCP is not required by this plan, but this option is available to you.

Selection of a Primary Care Physician

You can choose a provider based on geographic location, group practice, medical specialty, language spoken, or Hospital affiliation. See below on how to access the provider Directory online. Cigna's list of providers is updated several times a week. You may also call the toll-free number on your ID card or reach out to the Employee Health Clinic for help finding a provider.

Specialists and Other In-Network Providers

You may directly access Specialists and other health care professionals in the network for covered services and supplies under this SPD. Refer to the Cigna In-Network Provider Directory to locate in-network Specialists, providers and Hospitals in your area. Refer to the Schedule of Benefits section for benefit limitations and out-of-pocket costs applicable to your plan.

> **Important Notice:** You will receive an ID card which identifies you as a member when you receive services from health care providers. If you have not received your ID card or if your card is lost or stolen, you can:
>
> - Log into your Cigna account on a computer or mobile device to access a digital copy;
> - Request a copy through your Cigna account;
> - Contact the Benefits Specialist.

Accessing In-Network Providers and Benefits

- ☐ You may select an in-network provider from the In-Network Provider Directory or by logging on to Cigna's website at www.Cigna.com. You can search Cigna's online Directory for names and locations of Physicians and other health care providers and facilities.
- ☐ If a service you need is covered under the plan but not available from an in-network provider or Hospital in your area, please contact Member Services at the toll-free number on your ID card for assistance. If Member Services is not able to provide help, you may contact the Employee Health Clinic.
- ☐ Certain health care services such as Hospitalization, outpatient surgery and certain other outpatient services require Precertification with Cigna to verify coverage for these services. In-network providers will be responsible for obtaining necessary Precertification for you. Since Precertification is the provider's responsibility, there are no additional out-of-pocket costs to you as a result of an In-Network Provider's failure to Precertify services. Refer to the Understanding Precertification section for more information on the Precertification process and what to do if your request for Precertification is denied.
- ☐ You will not have to submit medical claims for treatment received from in-network health care professionals and facilities. Your In-Network Provider will take care of claim submission. Cigna will directly pay the In-Network Provider or facility less any cost sharing required by you. You will be responsible for Deductibles, Payment Percentage and Copayments, if any.

You will receive notification of what the plan has paid toward your Covered Expenses. This is called an Explanation of Benefits (EOB). EOBs can be accessed by logging into your Cigna account. It will indicate any amounts you owe towards your Deductible, Copayments, or Payment Percentage or other non-Covered Expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call Member Services if you have questions regarding your statement. If Member Services is unable to help, you may contact the Employee Health Clinic.

Cost Sharing for In-Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits section.

- ☐ You will need to satisfy any applicable Deductibles before the plan will begin to pay benefits.
- ☐ For certain types of services and supplies, you will be responsible for any Copayments shown in the Schedule of Benefits section.
- ☐ After you satisfy any applicable Deductible, you will be responsible for any applicable Payment Percentage for Covered Expenses that you incur. Your Payment Percentage is based on the Negotiated Charge. You will not have to pay any balance bills above the Negotiated Charge for that covered service or supply. You will be responsible for your Payment Percentage up to the Maximum Out-of-Pocket Limit applicable to your plan.
- ☐ Once you satisfy any applicable Maximum Out-of-Pocket Limit, the plan will pay 100% of the Covered Expenses that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the Maximum Out-of-Pocket Limit. Refer to the Schedule of Benefits section for information on what expenses do not apply and for the specific Maximum Out-of-Pocket Limit amounts that apply to your plan.
- ☐ The plan will pay for Covered Expenses, up to the maximums shown in the What the Plan Covers or Schedule of Benefits sections. You are responsible for any expenses incurred over the maximum limits outlined in the What the Plan Covers or Schedule of Benefits sections.
- ☐ You may be billed for any Deductible, Copayment, or Payment Percentage amounts, or any non-Covered Expenses that you incur.
- ☐ It is your responsibility to know if your provider is in, or out, of network. Your doctor is not responsible to only refer you to in-network providers, so please verify with each provider if they are in, or out, of network before you have your appointment

Cost Sharing for Out-of-Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits section.

- ☐ You will need to satisfy any applicable Deductibles before the plan will begin to pay benefits.
- ☐ For certain types of services and supplies, you will be responsible for any Copayments shown in the Schedule of Benefits section. After you satisfy any applicable Deductible, you will be responsible for any applicable Payment Percentage for Covered Expenses that you incur. You will be responsible for your Payment Percentage up to the Maximum Out-of-Pocket Limit applicable to your plan.
- ☐ Your Payment Percentage will be based on the Recognized Charge. If the health care provider you select charges more than the Recognized Charge, you will be responsible for any expenses above the Recognized Charge, even if you have met the annual maximum out of pocket.
- ☐ Once you satisfy any applicable Maximum Out-of-Pocket Limit, the plan will pay 100% of the Covered Expenses that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the Maximum Out-of-Pocket Limit. Refer to the Schedule of Benefits section for information on what expenses do not apply and for the specific Maximum Out-of-Pocket Limit amounts that apply to your plan.
- ☐ The plan will pay for Covered Expenses, up to the maximums shown in the What the Plan Covers or Schedule of Benefits sections. You are responsible for any expenses incurred over

the maximum limits outlined in the What the Plan Covers or Schedule of Benefits sections.

Understanding Precertification

Precertification

Certain services, such as inpatient Stays, certain tests, procedures and outpatient surgery require Precertification by Cigna. Precertification is a process that helps you and your Physician determine whether the services being recommended are Covered Expenses under the plan. It also allows Cigna to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

In-network providers will be responsible for obtaining necessary Precertification for you. It is your responsibility to make sure that the In-Network Provider has performed Precertification before the services take place. Since Precertification is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of an In-Network Provider's failure to Precertify services.

When you go to an Out-of-Network Provider, it is your responsibility to obtain Precertification from Cigna for any applicable services or supplies. If you do not Precertify, your benefits may be reduced, or the plan may not pay any benefits. The list of services requiring Precertification is below.

> **Important Notice:** If you sign a paper that says you will be financially responsible if insurance doesn't cover a service, then you can be held responsible for the full amount of that service.

The Precertification Process

Prior to being Hospitalized or receiving certain other medical services or supplies there are certain Precertification procedures that must be followed.

You or a member of your family, a Hospital staff member, or the attending Physician, must notify Cigna to Precertify the admission or medical services and expenses prior to receiving any of the services or supplies that require Precertification pursuant to this SPD in accordance with the following timelines.

Precertification should be secured within the timeframes specified below. To obtain Precertification, call Cigna at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your Physician or the facility will need to call and request Precertification at least 14 days before the date you are scheduled to be admitted.
For an emergency outpatient medical condition:	You or your Physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.

For an emergency admission:	You, your Physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an Urgent Admission:	You, your Physician or the facility will need to call before you are scheduled to be admitted. An Urgent Admission is a Hospital admission by a Physician due to the onset of or change in an Illness; the diagnosis of an Illness; or an Injury.
For outpatient non-emergency medical services requiring Precertification:	You or your Physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Cigna will notify you and your Physician of the Precertification decision. If your Precertified expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, Cigna will notify you, your Physician and the facility about your Precertified length of Stay. If your Physician recommends that your Stay be extended, additional days will need to be certified. You, your Physician, or the facility will need to call Cigna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Cigna will review and process the request for an extended Stay. You and your Physician will receive a notification of an approval or denial.

If Precertification determines that the Stay or services and supplies are not Covered Expenses, the notification will explain why and how Cigna's decision can be appealed. You or your provider may request a review of the Precertification decision pursuant to the Claims and Appeals section included with this SPD.

Services and Supplies Which Require Precertification

It is your responsibility to verify if Precertification is required for your service or supplies and to make sure that the In-Network Provider has performed Precertification before the services take place. If the service is out-of-network, it is also your responsibility to obtain Precertification from Cigna for any applicable services or supplies.

How Failure to Precertify Affects Your Benefits

A Precertification benefit reduction may be applied to the benefits paid if you fail to obtain a required Precertification prior to incurring medical expenses. This means Cigna may reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary Precertification from Cigna prior to receiving services from an Out-of-Network Provider. Your provider may Precertify your treatment for you; however, you should verify with Cigna prior to the procedure, that the provider has obtained Precertification from Cigna. If your treatment is not Precertified by you or your provider, the benefit payable may be significantly reduced or your expenses may not be covered.

How Your Benefits are Affected

The chart below illustrates the effect on your benefits if necessary Precertification is not obtained.

If Precertification is:	then the expenses are:
■ requested and approved by Cigna.	■ covered per the Schedule of Benefits
■ requested and denied.	■ not covered, may be appealed.
■ not requested, but would have been covered if requested.	■ covered per the Schedule of Benefits after a Precertification benefit reduction is applied.*
■ not requested, would not have been covered if requested.	■ not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because your Precertification requirement was not met will not count toward your Deductible or Payment Percentage or Maximum Out-of-Pocket Limit.

*Refer to the Schedule of Benefits section for the amount of Precertification benefit reduction that applies to your plan.

Emergency and Urgent Care

You have coverage 24 hours a day, 7 days a week, anywhere inside or outside the plan's Service Area, for:

- ☐ An Emergency Medical Condition; or
- ☐ An Urgent Condition.

In Case of a Medical Emergency

When Emergency Care is necessary, please follow the guidelines below:

- ☐ Go to the nearest emergency room, or dial 911 or your local emergency response service for medical and Ambulance help. If possible, call your Physician provided a delay would not be detrimental to your health.
- ☐ After assessing and stabilizing your condition, the emergency room should contact your Physician to obtain your medical history to assist the emergency Physician in your treatment.
- ☐ If you are admitted to an inpatient facility, notify your Physician as soon as reasonably possible.
- ☐ **If you seek care in an emergency room for a non-emergency condition, the plan may not cover the expenses you incur. Please refer to the Schedule of Benefits section for specific details about the plan. No other plan benefits will pay for non-Emergency Care in the emergency room unless otherwise specified under the plan.**

Coverage for Emergency Medical Conditions

Refer to Coverage for Emergency Medical Conditions in the What the Plan Covers section.

In Case of an Urgent Condition

Call your Physician if you think you need urgent care. If it is not feasible to contact your Physician, please do so as soon as possible after urgent care is provided. If you need help finding an Urgent Care

Provider you may call Member Services at the toll-free number on your I.D. card, or you may access Cigna's online provider Directory at www.Cigna.com.

Coverage for an Urgent Condition
Refer to Coverage for Urgent Medical Conditions in the What the Plan Covers section.

Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition
Follow-up care is not considered an emergency or Urgent Condition and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your Physician for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for Illness or Injury. If you access a Hospital emergency room for follow-up care, your expenses will not be covered and you will be responsible for the entire cost of your treatment. Refer to the Schedule of Benefits section for cost sharing information applicable to your plan.

To keep your out-of-pocket costs lower, your follow-up care should be provided by a Physician.

You may use an Out-of-Network Provider for your follow-up care. You will be subject to the Deductible and Payment Percentage that apply to out-of-network expenses, which may result in higher out-of-pocket costs to you.

> **Important Notice:** Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should not be provided by an emergency room facility.

Requirements For Coverage

To be covered by the plan, services and supplies must meet all of the following requirements:

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:
    - Be included as a covered expense in this SPD;
    - Not be an excluded expense under this SPD. Refer to the Exclusions sections of this SPD for a list of services and supplies that are excluded;
    - Not exceed the maximums and limitations outlined in this SPD. Refer to the What the Plan Covers and the Schedule of Benefits sections for information about certain expense and visit/day limits; and
    - Be obtained in accordance with all the terms, policies and procedures outlined in this SPD.
2. The service or supply must be provided while coverage is in effect. See the Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends and Continuation of Coverage sections for details on when coverage begins and ends.
3. The service or supply must be Medically Necessary. To meet this requirement, the medical services or supply must be provided by a Physician, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms. The provision of the service or supply must be:
    - In accordance with generally accepted standards of medical practice;
    - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
    - Not primarily for the convenience of the patient, Physician or other health care provider;
    - And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

> **Important Note:** Not every service or supply that fits the definition for Medical Necessity is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example, some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the What the Plan Covers and the Schedule of Benefits sections for the plan limits and maximums.

What The Plan Covers

Wellness, Physician Services, Hospital Expenses, Other Medical Expenses

Many preventive and routine medical expenses as well as expenses incurred for a serious Illness or Injury are covered. This section describes which expenses are Covered Expenses. Only expenses incurred for the services and supplies shown in this section are Covered Expenses. Limitations and exclusions apply.

Alcoholism, Substance Abuse and Mental Disorders Treatment

Covered Expenses include charges made for the treatment of alcoholism, Substance Abuse and Mental Disorders by Behavioral Health Providers.

Alcoholism and Substance Abuse

Covered Expenses include charges made for the treatment of alcoholism and Substance Abuse by Behavioral Health Providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- ☐ There is a written treatment plan supervised by a Physician or licensed provider; and
- ☐ This plan is for a condition that can be favorably changed.

The Schedule of Benefits section shows the benefits payable and applicable benefit maximums for the treatment of alcoholism and Substance Abuse.

Inpatient Treatment for Alcoholism and Substance Abuse

The plan covers Room and Board at the Semi-Private Room Rate and other services and supplies provided during your Stay in a Psychiatric Hospital or Residential Treatment Facility, appropriately licensed by the State Department of Health or its equivalent.

Coverage includes:

- Treatment in a Hospital for the medical complications of alcoholism or Substance Abuse.
- "Medical complications" include Detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a Hospital, when the Hospital does not have a separate treatment facility section.

Outpatient Treatment for Alcoholism and Substance Abuse

The plan covers outpatient treatment of alcoholism or Substance Abuse.

The plan covers partial Hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or Substance Abuse. The partial Hospitalization will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Partial Confinement Treatment for Alcoholism and Substance Abuse
Covered Expenses include charges made for Partial Confinement Treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or Substance Abuse.

The Partial Confinement Treatment will only be covered if you would need a Hospital Stay if you were not admitted to this type of facility.

Treatment of Mental Disorders
Covered Expenses include charges made for the treatment of other Mental Disorders by Behavioral Health Providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- ☐ There is a written treatment plan supervised by a Physician or licensed provider; and
- ☐ The plan is for a condition that can favorably be changed.

The Schedule of Benefits section shows the benefits payable and applicable benefit maximums for the treatment of Mental Disorders.

Benefits are payable for charges incurred in a Hospital, Psychiatric Hospital, Residential Treatment Facility or Behavioral Health Provider's office for the treatment of Mental Disorders as follows:

Inpatient Treatment
Covered Expenses include charges for Room and Board at the Semi-Private Room Rate, and other services and supplies provided during your Stay in a Hospital, Psychiatric Hospital or Residential Treatment Facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Partial Confinement Treatment
Covered Expenses include charges made for Partial Confinement Treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a Mental Disorder. Such benefits are payable if your condition requires services that are only available in a Partial Confinement Treatment setting.

Outpatient Treatment
Covered Expenses include charges for treatment received while not confined as a full-time inpatient in a Hospital, Psychiatric Hospital or Residential Treatment Facility.

The plan covers partial Hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial Hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Limitations:

- Inpatient visits for Alcoholism and Substance Abuse have a lifetime maximum of 2 courses of treatment. Refer to the Schedule of Benefits section.

- Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See the Health Plan Exclusions and Limits section for more information.

Important Reminders:

- Wayne County also provides a separate mental health benefit under our Employee Assistance Program (EAP) which is not a part of this Medical Plan. Please see the section for our EAP benefits for more details.
- Inpatient care must be Precertified by Cigna. Refer to the How the Plan Works section for more information about Precertification.

Alternatives to Hospital Stays

Home Health Care

Covered Expenses include charges made by a Home Health Care Agency for home health care, and the care:

- ☐ Is given under a Home Health Care Plan;
- ☐ Is given to you in your home while you are Homebound.

Home health care expenses include charges for:

- ☐ Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
- ☐ Part-time or intermittent home health aide services provided in conjunction with and in direct support of care by an R.N. or an L.P.N.
- ☐ Physical, occupational, and speech therapy.
- ☐ Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.
- ☐ Medical supplies, prescription drugs and lab services by or for a Home Health Care Agency to the extent they would have been covered under this plan if you had continued your Hospital Stay.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse or therapist is one visit. In figuring the Calendar Year Maximum Visits, each visit of up to 4 hours is one visit.

This maximum will not apply to care given by an R.N. or L.P.N. when:

- ☐ Care is provided within 10 days of discharge from a Hospital or Skilled Nursing Facility as a full-time inpatient; and
- ☐ Care is needed to transition from the Hospital or Skilled Nursing Facility to home care.

When the above criteria are met, Covered Expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or Custodial Care service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be

provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Limitations:

Unless specified above, not covered under this benefit are charges for:

- Services or supplies that are not a part of the Home Health Care Plan.
- Services of a person who usually lives with you, or who is a member of your or your Spouse's family.
- Services of a certified or licensed social worker.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are Custodial Care.

Important Reminders:

- The plan does not cover Custodial Care, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.
- Home health care needs to be Precertified by Cigna. Refer to the How the Plan Works section for details about Precertification.

Refer to the Schedule of Benefits section for details about any applicable home health care visit maximums.

Hospice Care

Covered Expenses include charges made by the following furnished to you for Hospice Care when given as part of a Hospice Care Program.

Facility Expenses

The charges made by a Hospital, hospice or Skilled Nursing Facility for:

- Room and Board and other services and supplies furnished during a Stay for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses

Covered Expenses include charges made on an outpatient basis by a Hospice Care Agency for:

- Part-time or intermittent nursing care by a R.N. or L.P.N. for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a Physician. These include but are not limited to:
    - Assessment of your social, emotional and medical needs, and your home and family situation;
    - Identification of available community resources; and
    - Assistance provided to you to obtain resources to meet your assessed needs.

- Physical and occupational therapy; and
- Consultation or case management services by a Physician;
- Medical supplies.
- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

Charges made by the providers below if they are not an employee of a Hospice Care Agency; and such Agency retains responsibility for your care:

- A Physician for a consultation or case management;
- A physical or occupational therapist;
- A Home Health Care Agency for:
    - Physical and occupational therapy;
    - Part time or intermittent home health aide services for your care up to eight hours a day;
    - Medical supplies;
    - Prescription drugs;
    - Psychological counseling; and
    - Dietary counseling.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Daily Room and Board charges over the Semi-Private Room Rate.
- Bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.
- Respite care. This is care furnished during a period of time when your family or usual caretaker cannot attend to your needs.

Important Reminders:

- Refer to the Schedule of Benefits section for details about any applicable Hospice Care maximums.
- Inpatient Hospice Care and home health care must be Precertified by Cigna. Refer to the How the Plan Works section for details about Precertification.

Outpatient Surgery and Physician Surgical Services

Covered Expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- ☐ A Physician or Dentist for professional services;
- ☐ A Surgery Center; or
- ☐ The outpatient department of a Hospital.

The surgery must meet the following requirements:

- ☐ The surgery can be performed adequately and safely only in a Surgery Center or Hospital and
- ☐ The surgery is not normally performed in a Physician's or Dentist's office.

The following outpatient surgery expenses are covered:

- ☐ Services and supplies provided by the Hospital, Surgery Center on the day of the procedure;
- ☐ The operating Physician's services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- ☐ Services of another Physician for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

Limitations

Not covered under this plan are charges made for:

- The services of a Physician or other health care provider who renders technical assistance to the operating Physician.
- A Stay in a Hospital.
- Facility charges for office-based surgery.

Important Notice: Benefits for surgery services performed in a Physician's or Dentist's office are described under Physician Services benefits in the previous section.

Skilled Nursing Facility

Covered Expenses include charges made by a Skilled Nursing Facility during your Stay for the following services and supplies, up to the maximums shown in the Schedule of Benefits section, including:

- ☐ Room and Board, up to the Semi-Private Room Rate. The plan will cover up to the private room rate if it is needed due to an infectious Illness or a weak or compromised immune system;
- ☐ Use of special treatment rooms;
- ☐ Radiological services and lab work;
- ☐ Physical, occupational, or speech therapy;
- ☐ Oxygen and other gas therapy;
- ☐ Other medical services and general nursing services usually given by a Skilled Nursing Facility (this does not include charges made for private or special nursing, or Physician's services); and
- ☐ Medical supplies.

Limitations

Unless specified above, not covered under this benefit are charges for:

- The treatment of:
  - Drug addiction;
  - Alcoholism;
  - Senility;

- Mental retardation; or
- Any other mental Illness; and

- Daily Room and Board over the semi-private rate.

Important Reminders:

- Refer to the Schedule of Benefits section for details about any applicable Skilled Nursing Facility maximums.
- Admissions to a Skilled Nursing Facility must be Precertified by Cigna. Refer to Using Your Medical Plan for details about Precertification.

Ambulance Service

Covered Expenses include charges made by a professional Ambulance, as follows:

Air or Water Ambulance

Covered Expenses include charges for transportation to a Hospital by air or water Ambulance when:

- ☐ Ground Ambulance transportation is not available; and
- ☐ Your condition is unstable, and requires medical supervision and rapid transport; and
- ☐ In a medical emergency, transportation from one Hospital to another Hospital; when the first Hospital does not have the required services or facilities to treat your condition and you need to be transported to another Hospital; and the two conditions above are met.

Ground Ambulance

Covered Expenses include charges for transportation:

- ☐ To the first Hospital where treatment is given in a medical emergency.
- ☐ From one Hospital to another Hospital in a medical emergency when the first Hospital does not have the required services or facilities to treat your condition.
- ☐ From Hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- ☐ From home to Hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition.
- ☐ When during a covered inpatient Stay at a Hospital, Skilled Nursing Facility or acute rehabilitation Hospital, an Ambulance is required to safely and adequately transport you to or from inpatient or outpatient Medically Necessary treatment.

Limitations

Not covered under this benefit are charges incurred to transport you:

- If an Ambulance service is not required by your physical condition; or
- If the type of Ambulance service provided is not required for your physical condition; or
- By any form of transportation other than a professional Ambulance service; or
- In non-emergency situations, Precertified transportation to a Hospital by a licensed Ambulance from home to Hospital if an Ambulance is the only safe way to transport is limited to 100-500 miles.

Autism Spectrum Disorder

Autism Spectrum Disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association. Eligible health services include the services and supplies provided by a Physician or Behavioral Health Provider for the diagnosis and treatment of Autism Spectrum Disorder. This treatment will only be covered if a Physician or Behavioral Health Provider orders it as part of a treatment plan.

Contraception

The Plan covers Contraceptives as currently required under the Affordable Care Act under the prescription benefit.

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a Physician, Hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an Illness or Injury, including:

- ☐ C.A.T. scans;
- ☐ Magnetic Resonance Imaging (MRI);
- ☐ Positron Emission Tomography (PET) Scans; and
- ☐ Any other outpatient diagnostic imaging service costing over $500.

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Outpatient Diagnostic Lab Work

Covered Expenses include charges for lab services, and pathology and other tests provided to diagnose an Illness or Injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a Physician. The charges must be made by a Physician, Hospital or licensed radiological facility or lab.

Important Reminder: Refer to the Schedule of Benefits section for details about any Deductible, Payment Percentage and maximum that may apply to outpatient diagnostic testing, and lab services.

Outpatient Diagnostic Radiological Services

Covered Expenses include charges for radiological services (other than complex imaging services), provided to diagnose an Illness or Injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a Physician. The services must be provided by a Physician, Hospital or licensed radiological facility.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Important Reminder: Refer to the Schedule of Benefits section for details about any Deductible, Payment Percentage and maximum that may apply to outpatient diagnostic radiological services.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, Covered Expenses include charges made for tests performed by a Hospital, Surgery Center, Physician or licensed diagnostic laboratory provided the charges for the surgery are Covered Expenses and the tests are:

- ☐ Related to your surgery, and the surgery takes place in a Hospital or Surgery Center;
- ☐ Completed within 14 days before your surgery;
- ☐ Performed on an outpatient basis;
- ☐ Covered if you were an inpatient in a Hospital;
- ☐ Not repeated in or by the Hospital or Surgery Center where the surgery will be performed.
- ☐ Test results should appear in your medical record kept by the Hospital or Surgery Center where the surgery is performed.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan. If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will not be covered.

Important Reminder: Complex Imaging testing for preoperative testing is covered under the complex imaging section. Separate cost sharing may apply. Refer to the Schedule of Benefits section for information on cost sharing amounts for complex imaging.

Durable Medical and Surgical Equipment (DME)

Covered prescribed expenses include charges by a DME supplier for the rental of equipment or, in lieu of rental:

- ☐ The initial purchase of DME if:
  - ■ Long term care is planned; and
  - ■ The equipment cannot be rented or is likely to cost less to purchase then to rent.
- ☐ Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.
- ☐ Replacement of purchased equipment if:
  - ■ The replacement is needed because of a change in your physical condition; and
  - ■ It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered Durable Medical Equipment includes those items covered by Medicare unless excluded in

the Exclusions section of this SPD. Cigna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Cigna.

> **Important Reminder:** Refer to the Schedule of Benefits section for details about Durable Medical and Surgical Equipment Deductible, Payment Percentage and benefit maximums. Also refer to the Exclusions section for information about Home and Mobility exclusions. DME is only covered through In-Network Providers.

Experimental or Investigational Treatment

Covered Expenses include charges made for Experimental or Investigational drugs, devices, treatments or procedures, provided all of the following conditions are met:

- ☐ You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- ☐ Standard therapies have not been effective or are inappropriate;
- ☐ Cigna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- ☐ There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
  - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
  - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
  - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
  - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
  - You are treated in accordance with protocol.

Gene-based, Cellular and Other Innovative Therapies (GCIT)

Covered services include GCIT provided by a Physician, Hospital or other provider.

Key Terms

Here are some key terms we use in this section. These will help you better understand GCIT.

- ☐ Gene: A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.
- ☐ Molecular: Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.
- ☐ Therapeutic: Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

GCIT are defined as any services that are:

- ☐ Gene-based
- ☐ Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. We call these "GCIT services."

GCIT covered services include:

- ☐ Cellular immunotherapies.
- ☐ Genetically modified oncolytic viral therapy.
- ☐ Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.
- ☐ All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. The following two therapies are the only two gene therapies covered by this plan.
    - ■ Luxturna® (Voretigene neparvovec)
    - ■ Spinraza® (Nusinersen)
- ☐ Products derived from gene editing technologies, including CRISPR-Cas9.
- ☐ Oligonucleotide-based therapies. Examples include:
    - ■ Antisense. An example is Spinraza.
    - ■ siRNA.
    - ■ mRNA.
    - ■ microRNA therapies.

Facilities/provider for gene-based, cellular and other innovative therapies
We designate facilities to provide GCIT services or procedures. GCIT Physicians, Hospitals and other providers are GCIT-designated facilities/providers for Cigna and CVS Caremark.

Exceptions:
The following are not covered services unless you receive prior written approval from us:

- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider.
- All associated services when GCIT services are not covered. Examples include:
    - Infusion
    - Lab
    - Radiology
    - Anesthesia
    - Nursing services
    - Zolgensma® (Onasemnogene abeparvovec-xioi)

Important Note: You must get GCIT covered services from the GCIT-designated facility/provider. If there are no GCIT-designated facilities/providers assigned in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you do not get your GCIT services at the facility/provider we designate, they will not be covered services.

Hearing Related Services

See Schedule of Benefits section for more coverage details. Our coverage for Hearing Related Services is limited to $2,000 of services every 3 years per member. This allowance will apply to testing and treatment of hearing related Injury, Illness and disease including the provision of hearing aids and hearing related devices. This includes:

- ☐ Bone anchored hearing aids;
- ☐ Cochlear implants;
- ☐ Any device meant to restore, enhance, or replace your hearing.

This does not include:

- ☐ Any hearing service that does not meet professionally accepted standards;
- ☐ Hearing exams given during a Stay in a Hospital or other facility.

Hospital Expenses

Covered medical expenses include services and supplies provided by a Hospital during your Stay.

Coverage for Emergency Medical Conditions

Covered Expenses include charges made by a Hospital or a Physician for services provided in an emergency room to evaluate and treat an Emergency Medical Condition.

The Emergency Care benefit covers:

- ☐ Use of emergency room facilities;
- ☐ Emergency room Physicians' services;
- ☐ Hospital nursing staff services; and
- ☐ Radiologists and pathologists' services.

Please contact your Physician after receiving treatment for an Emergency Medical Condition.

> **Important Reminder:** With the exception of Urgent Care described below, if you visit a Hospital emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the Schedule of Benefits section. No other plan benefits may pay for non-Emergency Care in the emergency room.

Coverage for Urgent Conditions

Covered Expenses include charges made by a Hospital or Urgent Care Provider to evaluate and treat an Urgent Condition.

Your coverage includes:

- ☐ Use of emergency room facilities when in-network urgent care facilities are not in the Service Area and you cannot reasonably wait to visit your Physician;
- ☐ Use of urgent care facilities;
- ☐ Physicians services;
- ☐ Nursing staff services; and
- ☐ Radiologists and pathologists' services.

Please contact your PCP after receiving treatment of an Urgent Condition.

Other Hospital Services and Supplies
Covered Expenses include charges made by a Hospital for services and supplies furnished to you in connection with your Stay.

Covered Expenses include Hospital charges for other services and supplies provided, such as:

- ☐ Ambulance services.
- ☐ Physicians and surgeons.
- ☐ Operating and recovery rooms.
- ☐ Intensive or special care facilities.
- ☐ Administration of blood and blood products, but not the cost of the blood or blood products.
- ☐ Radiation therapy.
- ☐ Speech therapy, physical therapy and occupational therapy.
- ☐ Oxygen and oxygen therapy.
- ☐ Radiological services, laboratory testing and diagnostic services.
- ☐ Medications.
- ☐ Intravenous (IV) preparations.
- ☐ Discharge planning.

Outpatient Hospital Expenses
Covered Expenses include Hospital charges made for covered services and supplies provided by the outpatient department of a Hospital.

Room and Board
Covered Expenses include charges for Room and Board provided at a Hospital during your Stay. Private room charges that exceed the Hospital's Semi-Private Room Rate are not covered unless a private room is required because of a contagious Illness or immune system problem.

Room and Board charges also include:

- ☐ Services of the Hospital's nursing staff;
- ☐ Admission and other fees;
- ☐ General and special diets; and
- ☐ Sundries and supplies.

Important Reminders:

- The plan will only pay for nursing services provided by the Hospital as part of its charge. The plan does not cover private duty nursing services as part of an inpatient Hospital Stay.
- If a Hospital or other health care facility does not itemize specific Room and Board charges and other charges, Cigna will assume that 40 percent of the total is for Room and Board charge, and 60 percent is for other charges.
- Hospital admissions need to be Precertified by Cigna. Refer to the How the Plan Works section for details about Precertification.
- In addition to charges made by the Hospital, certain Physicians and other providers may bill you separately during your Stay.

- Refer to the Schedule of Benefits section for any applicable Deductible, Copay and Payment Percentage and maximum benefit limits.

Jaw Joint Disorder Treatment

The plan covers charges made by a Physician, Hospital or Surgery Center for the diagnosis and surgical treatment of Jaw Joint Disorder. A Jaw Joint Disorder is defined as a painful condition:

- ☐ Of the jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome; or
- ☐ Involving the relationship between the jaw joint and related muscles and nerves such as myofacial pain dysfunction (MPD).

Unless specified above, not covered under this benefit are charges for non-surgical treatment of a Jaw Joint Disorder. This does not apply to in-mouth appliances needed for the treatment of a Jaw Joint Disorder.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered Expenses include charges made by a Physician, a Dentist and Hospital for:

- ☐ Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- ☐ Treat a fracture, dislocation, or wound.
- ☐ Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
- ☐ Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- ☐ Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a Stay required because of your condition.

Dental work, surgery and Orthodontic Treatment needed to remove, repair, restore or reposition:

- ☐ Natural teeth damaged, lost, or removed; or
- ☐ Other body tissues of the mouth fractured or cut due to Injury.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the Injury.

The treatment must be completed in the Calendar Year of the Accident or in the next Calendar Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to Injury, Covered Expenses only include charges for:

- ☐ The first denture or fixed bridgework to replace lost teeth;
- ☐ The first crown needed to repair each damaged tooth; and

- ☐ An in-mouth appliance used in the first course of Orthodontic Treatment after the Injury.

Physician Services

Alternatives to Physician Office Visits

Walk-in Clinic Visits

Covered Expenses include charges made by Walk-in Clinics for:

- ■ Unscheduled, non-emergency Illnesses and injuries; and the administration of certain immunizations administered within the scope of the clinic's license.

Anesthetics

Covered Expenses include charges for the administration of anesthetics and oxygen by a Physician, other than the operating Physician, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Physician Visits

Covered medical expenses include charges made by a Physician during a visit to treat an Illness or Injury. The visit may be at the Physician's office, in your home, in a Hospital or other facility during your Stay or in an outpatient facility. Covered Expenses also include:

- ☐ Immunizations for infectious disease, but not if solely for your employment;
- ☐ Allergy testing, treatment and injections; and
- ☐ Charges made by the Physician for supplies, radiological services, x-rays, and tests provided by the Physician.

Surgery

Covered Expenses include charges made by a Physician for:

- ☐ Performing your surgical procedure;
- ☐ Pre-operative and post-operative visits; and
- ☐ Consultation with another Physician to obtain a second opinion prior to the surgery.

Important Reminder: Certain procedures need to be Precertified by Cigna. Refer to the How the Plan Works section for more information about Precertification.

Pregnancy Related Expenses

Covered Expenses include charges made by a Physician for pregnancy and childbirth services and supplies at the same level as any Illness or Injury. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, Covered Expenses include charges made by a Hospital for a minimum of:

- ☐ 48 hours after a vaginal delivery; and
- ☐ 96 hours after a cesarean section.
- ☐ A shorter Stay, if the attending Physician, with the consent of the mother, discharges the mother or newborn earlier.

Covered Expenses also include charges made by a birthing center as described under Alternatives

to Hospital Care.

Covered Expenses also include services and supplies provided for circumcision of the newborn during the Stay.

> Important Notice: All current requirements outlined in the Newborns' and Mothers' Health Protection Act of 1996 are covered by the Plan.
>
> Important Reminder: Charges specific to the newborn child may be billed under the child as a dependent, and therefore, may require the family Deductible and out-of-pocket maximum to be met.

Preventive Care

This section on Preventive Care describes the Covered Expenses for services and supplies provided when you are well.

Hearing Exam

Covered Expenses include charges for an audiometric hearing exam if the exam is performed by:

- ☐ A Physician certified as an otolaryngologist or otologist; or
- ☐ An audiologist who:
  - ■ Is legally qualified in audiology; or
  - ■ Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
  - ■ Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam for any 24-month period.

All Covered Expenses for the hearing exam are subject to any applicable Deductible, Copay and Payment Percentage shown in the Schedule of Benefits section.

Routine Cancer Screenings

Covered Expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- ☐ mammograms;
- ☐ pap smears;
- ☐ gynecological exams;
- ☐ fecal occult blood tests;
- ☐ digital rectal exams;
- ☐ prostate specific antigen (PSA) tests;
- ☐ sigmoidoscopies;
- ☐ double contrast barium enemas (DCBE); and
- ☐ colonoscopies.

These benefits will be subject to any age; family history; and frequency guidelines as set forth in the

most current:

- ☐ Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and
- ☐ The comprehensive guidelines supported by the Health Resources and Services Administration.

Unless specified above, not covered under this benefit are charges incurred for:

- ☐ Services which are covered to any extent under any other part of this Plan.

Important Notices:

- Refer to the Schedule of Benefits section for details about cost sharing and benefit maximums that apply to Preventive Care.
- For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your Physician, log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.

Routine Physical Exams

Covered Expenses include charges made by your Physician for routine physical exams, including routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a Physician for a reason other than to diagnose or treat a suspected or identified Illness or Injury, and also includes:

- ☐ Radiological services, x-rays, lab and other tests given in connection with the exam;
- ☐ Immunizations for infectious diseases and the materials for administration of immunizations that have, in effect, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- ☐ Testing for Tuberculosis;
- ☐ For covered newborns, an initial Hospital checkup;
- ☐ Well visits (including routine oral screenings), for covered persons in accordance with the evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- ☐ The frequency of routine exams for newborns is as follows: 7 visits the first 12 months of life; 3 visits the second 12 months of life; 3 visits the third 12 months of life; and 1 visit per each 12-month period thereafter.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified Illness or Injury;
- Exams given during your Stay for medical care;
- Services not given by a Physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

Prosthetic Devices

Covered Expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by Illness, Injury or congenital defect. Covered Expenses also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or Injury or congenital defects as described in the list of covered devices below for an:

- ☐ Internal body part or organ; or
- ☐ External body part.

Covered Expenses also include replacement of a prosthetic device if:

- ☐ The replacement is needed because of a change in your physical condition; or normal growth or normal wear and tear; or
- ☐ It is likely to cost less to buy a new one than to repair the existing one; or
- ☐ The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- ☐ An artificial arm, leg, hip, knee or eye;
- ☐ Eye lens;
- ☐ An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- ☐ A breast implant after a mastectomy;
- ☐ Ostomy supplies, urinary catheters and external urinary collection devices;
- ☐ Speech generating device;
- ☐ A cardiac pacemaker and pacemaker defibrillators;
- ☐ Orthopedic shoes, therapeutic shoes, foot orthotics or other devices to support the feet. Coverage for these types of shoes, orthotics or devices is limited to a maximum of two (2) pairs in a calendar year period; and
- ☐ A durable brace that is custom made for and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:

- ☐ Trusses, corsets, and other support items;
- ☐ There is no coverage for hearing aids or any hearing related services and surgeries under the prosthetic section of this Plan;
- ☐ Any item listed in the Exclusions section.

Reconstructive or Cosmetic Surgery and Supplies

Covered Expenses include charges made by a Physician, Hospital, or Surgery Center for reconstructive services and supplies, including:

- ☐ Surgery needed to improve a significant functional impairment of a body part except this plan will not pay any benefit for the replacement of any hearing loss or defect.
- ☐ Surgery to correct the result of an Accidental Injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original Injury. For a covered child, the time period for coverage may be extended through age 18.

- ☐ Surgery to correct the result of an Injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original Injury.
- ☐ Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an Illness or Injury) when:
    - The defect results in severe facial disfigurement; or
    - The defect results in significant functional impairment and the surgery is needed to improve function.

    Note: Injuries that occur as a result of a medical (i.e., non-surgical) treatment are not considered Accidental injuries, even if unplanned or unexpected.

Reconstructive Breast Surgery

Covered Expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

The Plan provides coverage for:

- ☐ All stages of reconstruction of the breast on which the mastectomy has been performed;
- ☐ Surgery and reconstruction of the other breast to product a symmetrical appearance; and
- ☐ Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Important Notices:

- A benefit maximum may apply to reconstructive or Cosmetic surgery services. Please refer to the Schedule of Benefits section.
- All current requirements outlined in the Woman's Health and Cancer Rights Act of 1998 are covered by the Plan.

Sexual Dysfunction/Enhancement

The Plan covers sexual dysfunction and enhancement as currently required under the Affordable Care Act under the prescription benefit.

Short-Term Rehabilitation Therapy Services

Covered Expenses include charges for short-term therapy services when prescribed by a Physician as described below up to the benefit maximums listed in the Schedule of Benefits section. The services have to be performed by:

- ☐ A licensed or certified physical, occupational or speech therapist;
- ☐ A Hospital, Skilled Nursing Facility, or Hospice Facility; or
- ☐ A Physician.

Charges for the following short-term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits

- ☐ Cardiac rehabilitation benefits are available as part of an inpatient Hospital Stay. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a Physician. This course of treatment is limited to a maximum of 36 sessions in a 12-week period.
- ☐ Pulmonary rehabilitation benefits are available as part of an inpatient Hospital Stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a 6-week period.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits

Coverage is subject to the limits, if any, shown on the Schedule of Benefits section. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this SPD.

- ☐ Physical therapy is covered for non-chronic conditions and acute Illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute Illness, Injury or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- ☐ Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute Illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute Illness, Injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- ☐ Speech therapy is covered for non-chronic conditions and acute Illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from Illness or Injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- ☐ Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. Refer to the Schedule of Benefits section for the visit maximum that applies to the plan. Covered Expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- ☐ Details the treatment, and specifies frequency and duration; and
- ☐ Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Important Reminder: Refer to the Schedule of Benefits section for details about the short-term rehabilitation therapy maximum benefit.

Unless specifically covered above, not covered under this benefit are charges for:

- ☐ Therapies for the treatment of delays in development, unless resulting from acute Illness or Injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down's Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature;
- ☐ Any services which are Covered Expenses in whole or in part under any other group plan sponsored by an employer;
- ☐ Any services unless provided in accordance with a specific treatment plan;
- ☐ Services provided during a Stay in a Hospital, Skilled Nursing Facility, or Hospice Facility except as stated above;
- ☐ Services not performed by a Physician or under the direct supervision of a Physician;
- ☐ Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- ☐ Services provided by a Physician or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your Spouse's family;
- ☐ Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Specialized Care

Chemotherapy

Covered Expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient Hospitalization for chemotherapy is limited to the initial dose while Hospitalized for the diagnosis of cancer and when a Hospital Stay is otherwise Medically Necessary based on your health status.

Outpatient Infusion Therapy Benefits

Covered Expenses include charges made on an outpatient basis for infusion therapy by:

- ☐ A free-standing facility;
- ☐ The outpatient department of a Hospital; or
- ☐ A Physician in his/her office or in your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are Covered Expenses:

- ☐ The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- ☐ Professional services;
- ☐ Total parenteral nutrition (TPN);
- ☐ Chemotherapy;
- ☐ Drug therapy (includes antibiotic and antivirals);

- ☐ Pain management (narcotics); and
- ☐ Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- ☐ Enteral nutrition;
- ☐ Blood transfusions and blood products;
- ☐ Dialysis; and
- ☐ Insulin.

Coverage is subject to the maximums, if any, shown in the Schedule of Benefits section.

Coverage for inpatient infusion therapy is provided under the Inpatient Hospital and Skilled Nursing Facility Benefits sections of this SPD.

Benefits payable for infusion therapy will not count toward any applicable Home Health Care maximums.

Radiation Therapy Benefits

Covered Expenses include charges for the treatment of Illness by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

> **Important Reminder:** Refer to the Schedule of Benefits section for details on any applicable Deductible, Payment Percentage and maximum benefit limits.

Spinal Manipulation Treatment

Covered Expenses include charges made by a Physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your benefits are subject to the maximum shown in the Schedule of Benefits section. However, this maximum does not apply to expenses incurred:

- ☐ During your Hospital Stay; or
- ☐ For surgery. This includes pre- and post-surgical care provided or ordered by the operating Physician.

Transplant Services

Covered Expenses include charges incurred during a transplant Occurrence. The following will be considered to be one transplant Occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- ☐ Solid Organ (i.e. heart, lung, simultaneous pancreas kidney (SPK), pancreas, kidney, liver, intestine);
- ☐ Any other single organ transplant, unless otherwise excluded under the plan.
- ☐ Bone Marrow;
- ☐ Hematopoietic Stem Cell;
- ☐ CAR-T and T cell receptor therapy for FDA-approved treatments;

- ☐ Thymus tissue for FDA-approved treatments;
- ☐ Multiple organs replaced during one transplant surgery;
- ☐ Tandem transplants (Stem Cell);
- ☐ Sequential transplants;
- ☐ Re-transplant of same organ type within 180 days of the first transplant;

The following will be considered to be more than one Transplant Occurrence:

- ☐ Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- ☐ Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- ☐ Re-transplant after 180 days of the first transplant;
- ☐ Pancreas transplant following a kidney transplant;
- ☐ A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- ☐ More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The in-network level of benefits is paid only for a treatment received at a facility designated by the plan as an Institute of Excellence™ (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as Out-of-Network Services and Supplies, even if the facility is a in-network facility or IOE for other types of services.

The plan covers:

- ☐ Charges made by a Physician or transplant team.
- ☐ Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- ☐ Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- ☐ Charges for activating the donor search process with national registries.
- ☐ Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- ☐ Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant Occurrence.

A transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; or upon the date you are discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient Stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient Stay or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any Covered Expenses you incur from an IOE facility will be considered in-network care expenses.

Limitations

Unless specified above, not covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant Occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant Occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing Illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing Illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Cigna.

Important Reminders:

- To ensure coverage, all transplant procedures need to be Precertified by Cigna. Refer to the How the Plan Works section for details about Precertification.
- Refer to the Schedule of Benefits section for details about transplant expense maximums, if applicable.

Network of Transplant Specialist Facilities

Through the IOE network, you will have access to a provider network that specializes in

transplants. Benefits may vary if an IOE facility or non-IOE or Out-of-Network Provider is used. In addition, some expenses are payable only within the IOE network. The IOE facility must be specifically approved and designated by Cigna to perform the procedure you require. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Treatment of Infertility

Basic Infertility Expenses

Covered Expenses include charges made by a Physician to diagnose and to surgically treat the underlying medical cause of Infertility.

Medical Plan Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your Physician or Dentist. The plan covers only those services and supplies that are Medically Necessary and included in the What the Plan Covers section. Charges made for the following are not covered except to the extent listed under the What The Plan Covers section or by amendment attached to this SPD.

Acupuncture and related therapies
Acupuncture, acupressure and acupuncture therapy, except as provided in the What the Plan Covers section.

Allergy
Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

Behavioral Analysis Programs
Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.

Behavioral Health Services
- ☐ Alcoholism or Substance Abuse rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for Detoxification or treatment of alcoholism or Substance Abuse is specifically provided in the What the Plan Covers section.
- ☐ Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- ☐ Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- ☐ Treatment of antisocial personality disorder.
- ☐ Treatment in wilderness programs or other similar programs.
- ☐ Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the What the Plan Covers section of this SPD.

Blood Products
Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

Charges
Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this SPD.

Charges for a service or supply furnished by an In-Network Provider in excess of the Negotiated Charge, or an Out-of-Network Provider in excess of the Recognized Charge.

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed Hospital, Physician or other provider or not within the scope of the provider's license.

Contraception
Contraception, except as specifically described in the What the Plan Covers section.

Cosmetic Services and Plastic Surgery
Any treatment, surgery (Cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- ☐ Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, Cosmetic eyelid surgery and other surgical procedures;
- ☐ Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- ☐ Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- ☐ Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when Medically Necessary;
- ☐ Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- ☐ Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- ☐ Surgery to correct Gynecomastia;
- ☐ Breast augmentation;
- ☐ Otoplasty.

Counseling
Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor except as specifically provided in the What the Plan Covers section.

Court Ordered
Court ordered services, including those required as a condition of parole or release.

Dental Services
Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- ☐ services of Dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment

of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;

- ☐ dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- ☐ non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts.

Disposable Outpatient Supplies

Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

Drugs, Medications and Supplies

- ☐ Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
- ☐ Any services related to the dispensing, injection or application of a drug;
- ☐ Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- ☐ Immunizations related to work;
- ☐ Needles, syringes and other injectable aids;
- ☐ Drugs related to the treatment of non-Covered Expenses;
- ☐ Performance enhancing steroids;
- ☐ Injectable drugs if an alternative oral drug is available;
- ☐ Outpatient prescription drugs;
- ☐ Self-injectable prescription drugs and medications;
- ☐ Any prescription drugs, injectables, or medications or supplies provided by the customer or through a third-party vendor contract with the customer; and
- ☐ Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy except those specifically described in the What the Plan Covers section.

Educational Services

- ☐ Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- ☐ Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- ☐ Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Examinations
Any health examinations required:

- ☐ by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
- ☐ by any law of a government;
- ☐ for securing insurance, school admissions or professional or other licenses;
- ☐ to travel;
- ☐ to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and

Any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or Investigational
Experimental or Investigational drugs, devices, treatments or procedures, except as described in the What the Plan Covers section.

Facility Charges (Custodial Care)
Facility charges for care services or supplies provided in:

- ☐ rest homes;
- ☐ assisted living facilities;
- ☐ similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- ☐ health resorts;
- ☐ spas, sanitariums; or
- ☐ infirmaries at schools, colleges, or camps.

Food Items
Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Foot Care
Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

- ☐ treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- ☐ Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an Illness or Injury, except as specifically described in the What the Plan Covers section.

Growth/Height
Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

Hair Loss
Expenses for hair loss or hair transplants will not be considered eligible.

Home and Mobility
Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- ☐ Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds. and swimming pools;
- ☐ Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
- ☐ Equipment or supplies to aid sleeping or sitting, including non-Hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- ☐ Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- ☐ Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- ☐ Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your Illness or Injury;
- ☐ Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or Illness; and
- ☐ Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Home Births
Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Illegal Acts
Expenses for treatment, services and supplies resulting from Injury or Illness which is incurred while the Covered Person is taking part in, or attempting to take part in, an illegal act, even if the proximate cause of the Illness or Injury is not the illegal act itself. It is not necessary for an arrest to occur, charges to be filed, or a conviction to occur for this exclusion to apply. Notwithstanding the foregoing, any conviction or acquittal on any filed charges shall be conclusory. This exclusion does not apply to an Injury resulting from being a victim of an act of domestic violence or resulting from a documented and verified medical condition (including both physical and mental health conditions).

Infertility
Except as specifically described in the What the Plan Covers section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- ☐ Drugs related to the treatment of non-covered benefits;
- ☐ Injectable Infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- ☐ Artificial Insemination;
- ☐ Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); Artificial Insemination for covered females attempting to become pregnant who are not Infertile as defined by the plan;
- ☐ Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- ☐ Procedures, services and supplies to reverse voluntary sterilization;
- ☐ Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- ☐ The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- ☐ Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, Hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- ☐ Home ovulation prediction kits or home pregnancy tests;
- ☐ Any charges associated with care required to obtain ART Services (e.g., office, Hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- ☐ Ovulation induction and intrauterine insemination services if you are not Infertile.

Marijuana

Marijuana family of products; medical marijuana may be legal in Ohio, but it is not covered under this medical or prescription plan.

Medical Error

Treatment or services for unintended Injury or Illness resulting from an adverse consequence of care that could reasonably have been prevented, including foreign object left in body after surgery, surgery performed on wrong body part, air embolism, blood incompatibility, etc.

Medicare

Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous Charges

Miscellaneous charges for services or supplies including:

- ☐ Annual or other charges to be in a Physician's practice;
- ☐ Charges to have preferred access to a Physician's services such as boutique or concierge Physician practices;
- ☐ Cancelled or missed appointment charges or charges to complete claim forms;

- ☐ Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public Hospital or other facility is required to provide; or
  - Any care in a Hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Maintenance Care
Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

Non-Medically Necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not Medically Necessary, as determined by Cigna, for the diagnosis and treatment of Illness, Injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your Physician or Dentist.

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Private duty nursing during your Stay in a Hospital, and outpatient private duty nursing services, except as specifically described in the Private Duty Nursing provision of the What the Plan Covers section.

Non-Emergency Services outside the US
Any non-emergency charges incurred outside of the United States:
- ☐ if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this SPD, or
- ☐ such drugs or supplies are unavailable or illegal in the United States, or
- ☐ the purchase of such prescription drugs or supplies outside the United States is considered illegal.

Riot/Revolt
Expenses resulting from a Covered Person's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

Services
Services provided by a Spouse, domestic partner, parent, child, stepchild, brother, sister, in-law or

any household member.

Services of a resident Physician or intern rendered in that capacity.

Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

Services, including those related to pregnancy, rendered before your Effective Date or after the termination of your coverage, unless coverage is continued under the Continuation of Coverage section of this SPD.

Services that are not covered under this SPD.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Sexual Dysfunction/Enhancement

Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire except those specifically described in the What the Plan Covers section, including:

- ☐ Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- ☐ Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

Speech Therapy

Speech therapy for treatment of delays in speech development, except as specifically provided in the What the Plan Covers section. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

Spinal Disorder

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the What the Plan Covers section.

Strength and Performance Enhancement

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- ☐ Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- ☐ Drugs or preparations to enhance strength, performance, or endurance; and
- ☐ Treatments, services and supplies to treat Illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparations.

Surrogate
Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan and for any Covered Person other than the Employee and Spouse will not be considered eligible, including pre-pregnancy, conception, prenatal, childbirth and postnatal expenses. This exclusion does not apply to Preventive Services for any Covered Person as described under the What the Plan Covers section of the Plan.

Therapy
Therapies for the treatment of delays in development, unless resulting from acute Illness or Injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders, Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Therapies and tests: Any of the following treatments or procedures:

- ☐ Aromatherapy;
- ☐ Bio-feedback and bioenergetic therapy;
- ☐ Carbon dioxide therapy;
- ☐ Chelation therapy (except for heavy metal poisoning);
- ☐ Computer-aided tomography (CAT) scanning of the entire body;
- ☐ Educational therapy;
- ☐ Gastric irrigation;
- ☐ Hair analysis;
- ☐ Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- ☐ Hypnosis, and hypnotherapy, except when performed by a Physician as a form of anesthesia in connection with covered surgery;
- ☐ Lovaas therapy;
- ☐ Massage therapy;
- ☐ Megavitamin therapy;
- ☐ Primal therapy;
- ☐ Psychodrama;
- ☐ Purging;
- ☐ Recreational therapy;
- ☐ Rolfing;
- ☐ Sensory or auditory integration therapy;
- ☐ Sleep therapy;
- ☐ Thermograms and thermography.

Tobacco Use
Any treatment, service, supply or non-preventative drug to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically provided in the What the Plan Covers section.

Transplant
Transplant coverage does not include charges for:

- ☐ Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant Occurrence;
- ☐ Services and supplies furnished to a donor when recipient is not a covered person;
- ☐ Home infusion therapy after the transplant Occurrence;
- ☐ Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing Illness;
- ☐ Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing Illness;
- ☐ Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise Precertified by Cigna.

Transportation, Travel and Lodging
Transportation costs, including Ambulance services for routine transportation to receive outpatient or inpatient services except as described in the What the Plan Covers section.

Expenses for travel and lodging will not be considered eligible, except as specified under the What the Plan Covers section or the Centers of Excellence Program.

Unauthorized Services
Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by Cigna when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

Vision
Vision-related services and supplies, except as described in the What the Plan Covers section. The plan does not cover:

- ☐ Special supplies such as non-prescription sunglasses and subnormal vision aids;
- ☐ Vision service or supply which does not meet professionally accepted standards;
- ☐ Eye exams during your Stay in a Hospital or other facility for health care;
- ☐ Eye exams for contact lenses or their fitting;
- ☐ Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- ☐ Replacement of lenses or frames that are lost or stolen or broken;
- ☐ Acuity tests;
- ☐ Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- ☐ Services to treat errors of refraction.

Voluntary Termination of Pregnancy
Voluntary termination of pregnancy, including related services.

Weight
Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including Morbid Obesity, regardless of the existence of comorbid conditions; except as specifically provided in the What the Plan Covers section, including but not limited to:

- ☐ Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including Morbid Obesity;
- ☐ Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- ☐ Counseling, coaching, training, hypnosis or other forms of therapy; and
- ☐ Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Work Related

Any Illness or Injury related to employment or self-employment including any Illness or Injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an Occupational Illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular Illness or Injury under such law, that Illness or Injury will be considered "non-occupational" regardless of cause.

Workers' Compensation

Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Workers' Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Workers' Compensation or similar law and have reached the maximum reimbursement paid under Workers' Compensation or similar law will not be eligible for payment under this Plan.

When Coverage Ends

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees

Your health benefits coverage will end at the end of the month in which the following occurs if:

- ☐ The health benefits plan is discontinued;
- ☐ You voluntarily stop your coverage;
- ☐ You are no longer eligible for coverage;
- ☐ You do not make any required contributions;
- ☐ You become covered under another plan offered by your employer;
- ☐ Your employer notifies Cigna that your employment is ended;
- ☐ Your employment is terminated by your own choice;

If a covered employee dies, the coverage for the existing and covered dependents will continue until the end of the month, following the month of the employee's death.

It is your employer's responsibility to let Cigna know when your employment ends.

Inactive Pay Status

An employee who is not in an active pay status (vacation, comp/flex time, sick, paid/unpaid Family Medical Leave) is considered to be Inactive Pay Status and not eligible to be on the Plan. Please note that Workers' Comp is not considered active pay status.

- ☐ Please keep in mind that unpaid time off does not constitute active pay status for purposes of the Plan At the point that they are **not** in an active pay status, their insurance eligibility is over and they are terminated from the Plan on the last day of the month in which they were active. (for instance, an employee who is terminated from the Plan on May 9 would Stay on the Plan through May 31);
- ☐ Employees who return to active pay status within 60 calendar days of the date they are terminated from the Plan (using May 31 from the above example) will be able to start back on the Plan effective on the date they return to active pay status. They will not have to wait to join the Health Plan like a new employee;
- ☐ Employees who return to active pay status 61 or more calendar days from the date they are terminated from the Plan will be treated as a new employee for purposes of their Effective Date on the Plan;
- ☐ Employees who elect COBRA and are on COBRA on the date of their return to active pay status will start on the Plan effective on the date of their return, no matter if their return is over or under 60 days. These employees never left the Plan, so they do not have to wait like a new employee.

Examples:

- An employee who is out on paid leave and runs out of paid leave on May 8, but returns to active pay status on July 15, would be eligible to rejoin the plan with an Effective Date of July 15 (insurance *always* terms on the last date of the month in which the termination happens, so in this example, since insurance wouldn't have termed until May 31, it has

been less than 60 days).

- An employee who is out on paid leave and runs out of paid leave on May 8, but returns to active pay status on August 15, would be treated as a new employee with regard to the start date on the Plan, unless they elected COBRA and were carried by COBRA when they returned (because it has been over 60 days of not being on the Plan).

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- ☐ You are no longer eligible for dependents' coverage;
- ☐ You do not make the required contribution toward the cost of dependents' coverage;
- ☐ Your own coverage ends for any of the reasons listed under When Coverage Ends for Employees; if a covered employee dies, the coverage for the existing and covered dependents will continue until the end of the month, following the month of the employee's death.
- ☐ Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent no longer meets the plan's definition of a dependent (examples: divorce, child over 26 years of age, etc.); or
- ☐ As permitted under applicable federal and state law, your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer.
- ☐ *PLEASE NOTE that failure to notify Wayne County of a dependent termination, due to not meeting the plan's definition of a dependent, will result in the employee being responsible for 100 percent of any and all claims paid for that dependent after the date which they should have been terminated.*

COBRA benefits may apply to existing and covered dependents. Please refer to Section 7 of the Wayne County Employee Benefit Manual for more information.

Coverage for handicapped dependents may continue after your dependent reaches any Limiting Age. See Continuation of Coverage for more information.

Continuation of Coverage

COBRA

You and/or your dependents may be given the opportunity to continue health coverage under the Plan when you experience a loss of coverage under the Plan.

See Section 7 of the Wayne County Employee Benefit Manual for information regarding COBRA & USERRA continuation rights, including how long these benefits are available to you and how to elect and pay for these benefits.

Handicapped Dependent Children

Health Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- ☐ he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- ☐ he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Cigna no later than 31 days after the date your child reaches the maximum age under your plan.
Coverage will cease on the first to occur of:

- ☐ Cessation of the handicap.
- ☐ Failure to give proof that the handicap continues.
- ☐ Failure to have any required exam.
- ☐ Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

Cigna will have the right to require proof of the continuation of the handicap. Cigna also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

Coordination of Benefits – What Happens When There is More Than One Health Plan

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a Coordination of Benefits provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to account for payments made by "other plans".

When this and another health coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
   A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended. In such cases, Medicare rules will apply. See the When you have Medicare Coverage section. The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:
   - ☐ Covers the person as other than a dependent; and
   - ☐ Is secondary to Medicare.
2. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.
3. If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
4. In the case of a dependent child whose parents are divorced or separated:
   - ☐ If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
   - ☐ If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
   - ☐ If there is not such a court decree:

- If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
- If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:
   - ☐ The benefits of a plan which covers the person on whose expenses claim is based as a:
     - Laid-off or retired employee; or
     - The dependent of such person.
   - ☐ Shall be determined after the benefits of any other plan which covers such person as:
     - An employee who is not laid-off or retired; or
     - Dependent of such person.
   - ☐ If the other plan does not have a provision:
     - regarding laid-off or retired employees; and
     - as a result, each plan determines its benefits after the other;

     then the above paragraph will not apply.
   - ☐ The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.
   - ☐ If the other plan does not have a provision:
     - regarding right of continuation pursuant to federal or state law; and
     - as a result, each plan determines its benefits after the other;

     then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to Cigna for consideration, that have been grouped together for administrative purposes as a "claim transaction" in accordance with Cigna's then current rules. If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans.

In order to administer this provision, Cigna can release or obtain data. Cigna can also make or recover payments.

Other Plan
This means any other plan of health expense coverage under:

- ☐ Group insurance.
- ☐ Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- ☐ No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

When You Have Medicare Coverage

This section explains how the benefits under the Plan interact with benefits available under Medicare including Which Plan Pays First and How Coordination with Medicare Works.

Medicare, when used in this SPD, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare

You are eligible for Medicare if you are:

- ☐ Covered under it by reason of age, disability, or
- ☐ End Stage Renal Disease
- ☐ Not covered under it because you:
    - ■ Refused it;
    - ■ Dropped it; or
    - ■ Failed to make a proper request for it.

Which Plan Pays First
If you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, the plan is the primary payor, which means that the plan pays benefits before Medicare pays benefits. Under other circumstances, the plan is the secondary payor, and pays benefits after Medicare. To determine whether the Plan is primary or secondary, please visit https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance or call 1-877-319-0729.

How Coordination with Medicare Works

When the Plan is Primary
The plan pays benefits first when it is the primary payor. You may then submit your claim to Medicare for consideration.

When Medicare is Primary
Your health care expense must be considered for payment by Medicare first. You may then submit the expense to Cigna for consideration.

Cigna will calculate the benefits the plan would pay in the absence of Medicare:

The amount will be reduced so that when combined with the amount paid by Medicare, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B Deductible under Medicare will be applied under the plan in the order received by Cigna. Cigna will apply the largest charge first when two or more charges are received at the same time.

Cigna will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information
Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under This Plan and other plans. Cigna has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

General Provisions

Additional Provisions

The following additional provisions apply to your coverage:

- ☐ This SPD applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- ☐ You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- ☐ In the event of a misstatement of any fact affecting your coverage under the Plan, the true facts will be used to determine the coverage in force.
- ☐ This SPD describes the main features of the Plan. If you have any questions about the terms of the Plan or about the proper payment of benefits, contact your employer or Cigna.
- ☐ The Plan may be changed or discontinued with respect to your coverage.

Assignments

Coverage and your rights under this Plan may not be assigned. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding.

Claims, Appeals and External Review

Claims and Appeals

Filing Health Claims under the Plan

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claims and Appeals section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

Reporting of Claims

A claim must be submitted to Cigna showing proof of the nature and extent of the loss.

Claims must be submitted for payment to Cigna within one year of the date of service in order to be considered for payment. If a claim is submitted after one year from the date of service it will be denied.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Cigna. The notice will explain the reason for the denial and the appeal procedures available under the Plan.

Urgent Care Claims

An "Urgent Care Claim" is any claim for medical care or treatment for which the application of the

time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Cigna or your Physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Cigna's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Cigna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Cigna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Cigna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves

urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Health Claims – Standard Appeals

As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An "Adverse Benefit Determination" is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- ☐ Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- ☐ Coverage determinations, including plan limitations or exclusions;
- ☐ The results of any Utilization Review activities;
- ☐ A decision that the service or supply is Experimental or Investigational; or
- ☐ A decision that the service or supply is not Medically Necessary.

A "Final Internal Adverse Benefit Determination" is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Cigna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of Internal Appeals Process

Generally, you are required to complete all appeal processes of the Plan before being able to bring an action in litigation. However, if Cigna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may pursue any available remedies under state law, as applicable.

Full and Fair Review of Claim Determinations and Appeals

Cigna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Cigna (or at the direction of Cigna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Cigna at the address provided in this SPD, or, if your appeal is of an urgent nature, you may call Cigna's Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Cigna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Cigna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Cigna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Cigna's Member Services. Cigna's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Cigna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.
If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Cigna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Cigna within 60 days of receipt of the level one appeal decision. Cigna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

External Review
Cigna may deny a claim because it determines that the care is not appropriate or a service or treatment is Experimental or Investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with Cigna’s decision. An external review is a review by an independent clinical reviewer, selected by an External Review Organization, who has expertise in the problem or question involved.
To request an external review, the following requirements must be met:

- ☐ You have received notice of the denial of a claim by Cigna; and
- ☐ Your claim was denied because Cigna determined that the care was not necessary or was Experimental or Investigational; and
- ☐ The cost of the service or treatment in question for which you are responsible exceeds $500; and
- ☐ You have exhausted the applicable internal appeal processes.

The claim denial letter you receive from Cigna will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Cigna within 60 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Cigna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent clinical reviewer with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Cigna's contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of Cigna's receipt of your request form and all necessary information. A quicker review is possible if your Physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after Cigna receives the request.

Cigna, the Company and the Health Plan will abide by the decision of the External Review Organization, except where Cigna can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Cigna. Cigna is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

For more information about Cigna's External Review process, call the toll-free Customer Services telephone number shown on your ID card.

Appeal to the Plan Sponsor

If you choose to appeal to the Plan sponsor following an adverse determination by External Review where applicable or an adverse determination at the final level of standard appeals, you must do so in writing, and you should send the following information:

- ☐ The specific reason(s) for the appeal;
- ☐ Copies of all past correspondence with your Health Plan (including any EOBs); and
- ☐ Any applicable information that you have not yet sent to your Health Plan.

If you file a voluntary appeal, you will be deemed to authorize the Company to obtain information from your Health Plan relevant to your claim.

Mail your written appeal directly to:

Company Name:	**Wayne County HR Benefits Specialist**
Company Address:	**428 West Liberty Street**
	Wooster, Ohio 44691

The Company will review your appeal. The Company reviewer will evaluate your claim within 60 days after you file your appeal and make a decision. If the reviewer needs more time, the reviewer may take an additional 60-day period. The reviewer will notify you in advance of this extension.

The Company reviewer will follow relevant internal rules maintained by the applicable Health Plan to the extent they do not conflict with its own internal guidelines.

The Company reviewer will notify you of the final decision on your appeal electronically or in writing. The written notice will give you the reason for the decision and what Plan provisions apply.

All decisions by the Company with respect to your claim shall be final and binding.

Contacting Cigna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to Cigna, you may contact Cigna using their toll-free Member Services phone number on your ID card or visit Cigna's web site at www.Cigna.com.

Discount Programs

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, Dentists, alternative medicine, wellness and healthy living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to Cigna in exchange for making these services available.

The third-party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

Failure to Provide Required Documentation

Dependents could be terminated from your plan or denied coverage if you fail to submit required birth and/or marriage certificates either at the time of enrollment or as the result of an eligibility audit.

Governing Laws

This Plan is a governmental sponsored plan and as such it is exempt from the requirement of the Employee Retirement Income Security Act of 1974 (ERISA), which is a Federal law regulating Employee welfare and pension plans. The Covered Person's rights in the Plan are governed by the plan documents and applicable Ohio law and regulations.

Health Savings Account Benefits

If you have chosen the High-Deductible Plan, you will need to set up a Health Savings Account (HSA) at your choice of banks. An HSA is an account that allows you to save money to help pay for qualified medical expenses; this money is never taxed if it is spent on qualifying medical expenses.

It is your responsibility to:

- ☐ Make sure all earned, given and personal contributions do not exceed IRS maximum limits.

- ☐ Make sure your HSA is only used to pay for eligible healthcare costs. We recommend saving all receipts which are paid from your HSA to prove those payments/costs were for eligible purposes, in case your account is audited by the IRS.
- ☐ Make sure an additional form is completed at tax time, IRS Form #8889; please communicate this with your tax return preparer.
- ☐ Refer to IRS Publication 969 and IRS Publication 502 for more information and a list of eligible purposes.
- ☐ Make sure you are eligible for an HSA. You are not eligible if:
    - You (or any of your enrolled dependents) are enrolled in Medicare or Medicaid.
    - You (or any of your enrolled dependents) are enrolled in Veterans medical services.
    - You (or any of your enrolled dependents) are on a low Deductible plan elsewhere.
    - You (or any of your enrolled dependents) are claimed as a dependent on someone else's return.

In the event that you are eligible for an HSA and you do not establish your HSA, submit your HSA banking information, and have it approved on or before the last day of February in any given year, then the Plan is not required to make any contributions to your HSA for the previous calendar year.

Legal Action

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Misstatements

Failure to implement or insist upon compliance with any provision of this Cigna medical benefits plan at any given time or times, shall not constitute a waiver of the Plan's right to implement or insist upon compliance with that provision at any other time or times.

Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this Plan.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Proof must be provided for all benefits.

All covered health benefits are payable to you. However, Cigna has the right to pay any health benefits to the service provider. This will be done unless you have told Cigna otherwise by the time you file the claim.

The Plan may pay up to $1,000 of any other benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release.

When a PCP provides care for you or a covered dependent, or care is provided by an In-Network Provider (In-Network Services or supplies), the In-Network Provider will take care of filing claims. However, when you seek care on your own (Out-of-Network Services and Supplies), you may be

responsible for filing your own claims.

Physical Examinations

Cigna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

Subrogation and Right of Recovery Provision

Definitions

As used throughout this provision, the term Responsible Party means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's Injury, Illness or condition. The term Responsible Party includes the liability insurer of such party or any Insurance Coverage.

For purposes of this provision, the term Insurance Coverage refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile Insurance Coverage, or any first party Insurance Coverage.

For purposes of this provision, a Covered Person includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation

Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's Injury, Illness or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an Injury, Illness or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the plan has paid and will pay as a result of that Injury, Illness or condition, from such payment, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an Injury, Illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the Illness, Injury or condition for which Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any Insurance Coverage, related to treatment for any Illness, Injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that the plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to Injury, Illness or condition sustained by the Covered Person. The Covered Person and his/her agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights, or failure to reimburse the plan from any settlement or recovery obtained by the Covered Person, may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of the plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to investigate regarding the Injury, Illness or condition to identify any Responsible Party. The plan reserves the right to notify Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- ☐ Names of Physicians, Dentists and others who furnish services.
- ☐ Dates expenses are incurred.
- ☐ Copies of all bills and receipts.

Recovery of Overpayments

Health Coverage

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right:

- ☐ To require the return of the overpayment; or
- ☐ To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan.

Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator – Cigna. Under this process, Cigna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the Plan that overpaid the provider. Payments to providers under this Plan are

subject to this same process when Cigna recovers overpayments for other plans administered by Cigna.

Such right does not affect any other right of recovery the Plan may have with respect to overpayments.

Workers' Compensation

If benefits are paid under the Plan and the Plan determines you received Workers' Compensation benefits for the same incident, the Plan has the right to recover as described under the "Subrogation and Right of Reimbursement" provision. Cigna, on behalf of the Plan, will exercise its right to recover against you.

The Recovery Rights will be applied even though:

- ☐ The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise; or
- ☐ No final determination is made that bodily Injury or Illness was sustained in the course of or resulted from your employment; or
- ☐ The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier; or
- ☐ The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the Plan, you will notify Cigna of any Workers' Compensation claim you make, and that you agree to reimburse Cigna, on behalf of the Plan, as described above.

If benefits are paid under the Plan, and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, the Plan has a right to recover from you or your covered dependent an amount equal to the amount the Plan paid.

Type of Coverage

Coverage under the plan is non-occupational. Only non-occupational injuries and Non-Occupational Illnesses are covered. The plan covers charges made for services and supplies only while the person is covered under the Plan.

Glossary

This section only provides definitions and does not indicate coverage, or lack of coverage for any item. To determine what is and is not covered, you must carefully read this entire SPD and the appropriate Schedule of Benefits sections.

A

Accident/Accidental
This means a sudden; unexpected; and unforeseen; identifiable Occurrence or event producing, at the time, objective symptoms of a bodily Injury. The Accident must occur while the person is covered under this Contract. The Occurrence or event must be definite as to time and place. It must not be due to, or contributed by, an Illness or disease of any kind.

Cigna
Cigna HealthCare, an affiliate, or a third party vendor under contract with Cigna.

Ambulance
A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

B

Behavioral Health Provider/Practitioner
A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Body Mass Index
This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

C

Child Support Order
As defined in Ohio Revised Code 3119.01.

Copay or Copayment
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various Copayments, and these Copayment amounts or percentages are specified in the Schedule of Benefits section.

Cosmetic
Services or supplies that alter, improve or enhance appearance.

Covered Expenses
Medical, dental, vision or hearing services and supplies shown as covered under this SPD.

Custodial Care
Services and supplies that are primarily intended to help you meet personal needs. Custodial Care can be prescribed by a Physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of Custodial Care include:

- ☐ Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- ☐ Care of a stable tracheostomy (including intermittent suctioning);
- ☐ Care of a stable colostomy/ileostomy;
- ☐ Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- ☐ Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- ☐ Watching or protecting you;
- ☐ Respite care, adult (or child) day care, or convalescent care;
- ☐ Institutional care, including Room and Board for rest cures, adult day care and convalescent care;
- ☐ Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- ☐ Any services that a person without medical or paramedical training could be trained to perform; and
- ☐ Any service that can be performed by a person without any medical or paramedical training.

D

Day Care Treatment
A Partial Confinement Treatment program to provide treatment for you during the day. The Hospital, Psychiatric Hospital or Residential Treatment Facility does not make a room charge for Day Care Treatment. Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

Deductible
The part of your Covered Expenses you pay before the plan starts to pay benefits. Additional information regarding Deductibles and Deductible amounts can be found in the Schedule of Benefits section.

Dentist
A legally qualified Dentist, or a Physician licensed to do the dental work he or she performs.

Detoxification
The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by

metabolic or other means, the:

- ☐ Intoxicating alcohol or drug;
- ☐ Alcohol or drug-dependent factors; or
- ☐ Alcohol in combination with drugs;

as determined by a Physician. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory
A listing of all In-Network Providers serving the class of employees to which you belong. In-Network Provider information is also available through Cigna's online provider Directory.

Durable Medical and Surgical Equipment (DME)
Equipment, and the accessories needed to operate it, that is:

- ☐ Made to withstand prolonged use;
- ☐ Made for and mainly used in the treatment of an Illness or Injury;
- ☐ Suited for use in the home;
- ☐ Not normally of use to people who do not have an Illness or Injury;
- ☐ Not for use in altering air quality or temperature; and
- ☐ Not for exercise or training.

DME does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

Updated 1/1/19

E

Effective Date
The date that a member's plan becomes effective. If you do not elect coverage, then you will not have an Effective Date.

Eligibility Date
The date you become eligible for benefits (not including any waiting period).

Emergency Care
This means the treatment given in a Hospital's emergency room to evaluate and treat an Emergency Medical Condition.

Emergency Medical Condition
A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, Illness, or Injury is of such a nature that failure to get immediate medical care could result in:

- ☐ Placing your health in serious jeopardy; or
- ☐ Serious impairment to bodily function; or
- ☐ Serious dysfunction of a body part or organ; or

- ☐ In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational
A drug, a device, a procedure, or treatment will be determined to be Experimental or Investigational if:

- ☐ There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the Illness or Injury involved; or
- ☐ Approval required by the FDA has not been granted for marketing; or
- ☐ A recognized national medical or dental society or regulatory agency has determined, in writing, that it is Experimental or Investigational, or for research purposes; or
- ☐ It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- ☐ The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is Experimental or Investigational, or for research purposes.

H

Homebound
This means that you are confined to your place of residence:

- ☐ Due to an Illness or Injury which makes leaving the home medically contraindicated; or
- ☐ Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered Homebound include (but are not limited to) the following:

- ☐ You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- ☐ You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency
An agency that meets all of the following requirements.

- ☐ Mainly provides skilled nursing and other therapeutic services.
- ☐ Is associated with a professional group (of at least one Physician and one R.N.) which makes policy.
- ☐ Has full-time supervision by a Physician or an R.N.
- ☐ Keeps complete medical records on each person.
- ☐ Has an administrator.
- ☐ Meets licensing standards.

Home Health Care Plan
This is a plan that provides for continued care and treatment of an Illness or Injury. The care and

treatment must be:

- ☐ Prescribed in writing by the attending Physician; and
- ☐ An alternative to a Hospital or Skilled Nursing Facility Stay.

Hospice Care

This is care given to a Terminally Ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

Hospice Care Agency

An agency or organization that meets all of the following requirements:

- ☐ Has Hospice Care available 24 hours a day.
- ☐ Meets any licensing or certification standards established by the jurisdiction where it is located.
- ☐ Provides:
  - ■ Skilled Nursing Services;
  - ■ Medical social services; and
  - ■ Psychological and dietary counseling.
- ☐ Provides, or arranges for, other services which include:
  - ■ Physician services;
  - ■ Physical and occupational therapy;
  - ■ Part-time home health aide services which mainly consist of caring for Terminally Ill people; and
  - ■ Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- ☐ Has at least the following personnel:
  - ■ One Physician;
  - ■ One R.N.; and
  - ■ One licensed or certified social worker employed by the agency.
- ☐ Establishes policies about how Hospice Care is provided.
- ☐ Assesses the patient's medical and social needs.
- ☐ Develops a Hospice Care Program to meet those needs.
- ☐ Provides an ongoing quality assurance program. This includes reviews by Physicians, other than those who own or direct the agency.
- ☐ Permits all area medical personnel to utilize its services for their patients.
- ☐ Keeps a medical record on each patient.
- ☐ Uses volunteers trained in providing services for non-medical needs.
- ☐ Has a full-time administrator.

Hospice Care Program

This is a written plan of Hospice Care, which:

- ☐ Is established by and reviewed from time to time by a Physician attending the person, and appropriate personnel of a Hospice Care Agency;
- ☐ Is designed to provide palliative and supportive care to Terminally Ill persons, and supportive care to their families; and
- ☐ Includes an assessment of the person's medical and social needs; and a description of the care

to be given to meet those needs.

Hospice Facility
A facility, or distinct part of one, that meets all of the following requirements:

- ☐ Mainly provides inpatient Hospice Care to Terminally Ill persons.
- ☐ Charges patients for its services.
- ☐ Meets any licensing or certification standards established by the jurisdiction where it is located.
- ☐ Keeps a medical record on each patient.
- ☐ Provides an ongoing quality assurance program including reviews by Physicians other than those who own or direct the facility.
- ☐ Is run by a staff of Physicians. At least one staff Physician must be on call at all times.
- ☐ Provides 24-hour-a-day nursing services under the direction of an R.N.
- ☐ Has a full-time administrator.

Hospital
An institution that:

- ☐ Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- ☐ Is supervised by a staff of Physicians;
- ☐ Provides twenty-four (24) hour-a-day R.N. service,
- ☐ Charges patients for its services;
- ☐ Is operating in accordance with the laws of the jurisdiction in which it is located; and
- ☐ Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a Hospital and is accredited as a Hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does Hospital include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, Skilled Nursing Facility, hospice, rehabilitative Hospital or facility primarily for rehabilitative or custodial services.

Hospitalization
A continuous confinement as an inpatient in a Hospital for which a Room and Board charge is made.

I

Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or Infertility
The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- ☐ For a woman who is under 35 years of age: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- ☐ For a woman who is 35 years of age or older: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Injury
An Accidental bodily Injury that is the sole and direct result of:
- ☐ An unexpected or reasonably unforeseen Occurrence or event; or
- ☐ The reasonable unforeseeable consequences of a voluntary act by the person.
- ☐ An act or event must be definite as to time and place.

In-Network Provider
A health care provider who has contracted to furnish services or supplies for this plan; but only if the provider is, with Cigna's consent, included in the Directory as an In-Network Provider for:
- ☐ The service or supply involved; and
- ☐ The class of employees to which you belong.

In-Network Service(s) or Supply(ies)
Health care service or supply that is:
- ☐ Furnished by an In-Network Provider; or
- ☐ Furnished or arranged by your PCP.

Institute of Excellence (IOE)
A Hospital or other facility that has contracted with Cigna to furnish services or supplies to an IOE patient in connection with specific transplants at a Negotiated Charge. A facility is an IOE facility only for those types of transplants for which it has signed a contract.

J

Jaw Joint Disorder
This is:
- ☐ A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint; or
- ☐ A Myofacial Pain Dysfunction (MPD); or
- ☐ Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L

Life Event
An event that qualifies eligible employees to make changes to their insurance plan. Life Events include the same considerations that are made for Special Enrollment Periods as defined by the IRS.

Limiting Age
Under Federal Law, Eligible Children over the age of 26 are no longer eligible for coverage.

L.P.N.
A licensed practical or vocational nurse.

M

Maintenance Care
Care made up of services and supplies that:

- ☐ Are furnished mainly to maintain, rather than to improve, a level of physical, or mental function; and
- ☐ Provide a surrounding free from exposures that can worsen the person's physical or mental condition.

Maximum Out-of-Pocket Limit
Your plan has a Maximum Out-of-Pocket Limit. Your Deductibles, Copays, Payment Percentage and other eligible out-of-pocket expense apply to the Maximum Out-of-Pocket Limit. Once you satisfy the maximum amount the plan will pay 100% of Covered Expenses that apply toward the limit for the rest of the calendar year. There are separate Maximum Out-of-Pocket Limits that apply to both in-network and out-of-network out-of-pocket expenses.

Medically Necessary or Medical Necessity
Health care or dental services, and supplies or prescription drugs that a Physician, other health care provider or dental provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

- ☐ In accordance with generally accepted standards of medical or dental practice;
- ☐ Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
- ☐ Not primarily for the convenience of the patient, Physician, other health care or dental provider; and
- ☐ Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with Physician or dental specialty society recommendations and the views of Physicians or Dentists practicing in relevant clinical areas and any other relevant factors.

Mental Disorder
An Illness commonly understood to be a Mental Disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a Behavioral Health Provider such as a Psychiatric Physician, a psychologist or a psychiatric social worker. A Mental Disorder includes; but is not limited to:

- ☐ Alcoholism and Substance Abuse.

- ☐ Bipolar disorder.
- ☐ Major depressive disorder.
- ☐ Obsessive compulsive disorder.
- ☐ Panic disorder.
- ☐ Pervasive Mental Developmental Disorder (Autism).
- ☐ Psychotic depression.
- ☐ Schizophrenia.

For the purposes of benefits under this plan, Mental Disorder will include alcoholism and Substance Abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and Substance Abuse.

Morbid Obesity
This means a Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

N

Negotiated Charge
The maximum charge an In-Network Provider has agreed to make as to any service or supply for the purpose of the benefits under this plan.

Night Care Treatment
A Partial Confinement Treatment program provided when you need to be confined during the night. A room charge is made by the Hospital, Psychiatric Hospital or Residential Treatment Facility. Such treatment must be available at least:
- ☐ 8 hours in a row a night; and
- ☐ 5 nights a week.

Non-Occupational Illness
An Illness that does not:
- ☐ Arise out of (or in the course of) any work for pay or profit; or
- ☐ Result in any way from an Illness that does.

An Illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:
- ☐ Is covered under any type of workers' compensation law; and
- ☐ Is not covered for that Illness under such law.

Non-Occupational Injury
An Accidental bodily Injury that does not:
- ☐ Arise out of (or in the course of) any work for pay or profit; or
- ☐ Result in any way from an Injury which does.

Non-Specialist
A Physician who is not a Specialist.

O

Occupational Injury or Occupational Illness
An Injury or Illness that:

- ☐ Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full-time basis; or
- ☐ Results in any way from an Injury or Illness that does.

Occurrence
This means a period of disease or Injury. An Occurrence ends when 60 consecutive days have passed during which the covered person:

- ☐ Receives no medical treatment; services; or supplies; for a disease or Injury; and
- ☐ Neither takes any medication, nor has any medication prescribed, for a disease or Injury.

Orthodontic Treatment
This is any:

- ☐ Medical service or supply; or
- ☐ Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- ☐ Of the teeth; or
- ☐ Of the bite; or
- ☐ Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered Orthodontic Treatment:

- ☐ The installation of a space maintainer; or
- ☐ A surgical procedure to correct malocclusion.

Out-of-Network Service(s) and Supply(ies)
Health care service or supply that is:

- ☐ Furnished by an Out-of-Network Provider; or
- ☐ Not furnished or arranged by your PCP.

Out-of-Network Provider
A health care provider who has not contracted with Cigna, an affiliate, or a third-party vendor, to furnish services or supplies for this plan.

P

Partial Confinement Treatment
A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat alcoholism, Substance Abuse, or Mental Disorders. The plan must meet these tests:

- ☐ It is carried out in a Hospital; Psychiatric Hospital or Residential Treatment Facility; on less than a full-time inpatient basis.
- ☐ It is in accord with accepted medical practice for the condition of the person.
- ☐ It does not require full-time confinement.
- ☐ It is supervised by a Psychiatric Physician who weekly reviews and evaluates its effect.
- ☐ Day Care Treatment and Night Care Treatment are considered Partial Confinement Treatment.

Payment Percentage
This is both the percentage of Covered Expenses that the plan pays, and the percentage of Covered Expenses that you pay. Once applicable Deductibles have been met, your plan will pay a percentage of the Covered Expenses, and you will be responsible for the rest of the costs. The percentage that the plan pays may vary by the type of expense. The percentage that you pay is also known as "Co-Insurance". Please refer to the Schedule of Benefits section for specific information on Payment Percentage amounts for each covered benefit.

Physician
A duly licensed member of a medical profession who:

- ☐ Has an M.D. or D.O. degree;
- ☐ Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- ☐ Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- ☐ Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- ☐ Provides medical services which are within the scope of his or her license or certificate;
- ☐ Under applicable insurance law is considered a "Physician" for purposes of this coverage;
- ☐ Has the medical training and clinical expertise suitable to treat your condition;
- ☐ Specializes in psychiatry, if your Illness or Injury is caused, to any extent, by alcohol abuse, Substance Abuse or a Mental Disorder; and
- ☐ A Physician is not you or related to you.

Precertification or Precertify
A process where Cigna is contacted before certain services are provided, such as Hospitalization or outpatient surgery, or prescription drugs are prescribed to determine whether the services being recommended or the drugs prescribed are considered Covered Expenses under the plan. It is not a guarantee that benefits will be payable.

Primary Care Physician (PCP)
This is the In-Network Provider who:

- ☐ Is selected by a person from the list of Primary Care Physicians in the Directory;

- ☐ Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- ☐ Is shown on Cigna's records as the person's PCP.

Psychiatric Hospital
This is an institution that meets all of the following requirements.

- ☐ Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, Substance Abuse or Mental Disorders.
- ☐ Is not mainly a school or a custodial, recreational or training institution.
- ☐ Provides infirmary-level medical services. Also, it provides, or arranges with a Hospital in the area for, any other medical service that may be required.
- ☐ Is supervised full-time by a Psychiatric Physician who is responsible for patient care and is there regularly.
- ☐ Is staffed by Psychiatric Physicians involved in care and treatment.
- ☐ Has a Psychiatric Physician present during the whole treatment day.
- ☐ Provides, at all times, psychiatric social work and nursing services.
- ☐ Provides, at all times, Skilled Nursing Services by licensed nurses who are supervised by a full-time R.N.
- ☐ Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a Psychiatric Physician.
- ☐ Makes charges.
- ☐ Meets licensing standards.

Psychiatric Physician
This is a Physician who:

- ☐ Specializes in psychiatry; or
- ☐ Has the training or experience to do the required evaluation and treatment of alcoholism, Substance Abuse or Mental Disorders.

R

Recognized Charge
The covered expense is only that part of a charge which is the Recognized Charge.

As to medical, vision and hearing expenses, the Recognized Charge for each service or supply is the lesser of:

- ☐ What the provider bills or submits for that service or supply; and
- ☐ For professional services and other services or supplies not mentioned below:
    - ■ The 80th percentile of the Prevailing Charge Rate; for the Geographic Area where the service is furnished.

If Cigna has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that Cigna will pay for a service or supply, then the Recognized Charge is the rate established in such agreement.

Cigna may also reduce the Recognized Charge by applying Cigna Reimbursement Policies. Cigna

Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- ☐ The duration and complexity of a service;
- ☐ Whether multiple procedures are billed at the same time, but no additional overhead is required;
- ☐ Whether an assistant surgeon is involved and necessary for the service;
- ☐ If follow up care is included;
- ☐ Whether there are any other characteristics that may modify or make a particular service unique; and
- ☐ When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Cigna Reimbursement Policies are based on Cigna's review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas. Cigna uses a commercial software package to administer some of these policies.
As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- ☐ Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- ☐ Prevailing Charge Rates: These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. Cigna updates its systems with these changes within 180 days after receiving them from FAIR Health.

Important Note:
Cigna periodically updates its systems with changes made to the Prevailing Charge Rates.

What this means to you is that the Recognized Charge is based on the version of the rates that is in use by Cigna on the date that the service or supply was provided.

Additional Information:
Cigna's website www.Cigna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Cigna Member Website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools, or contact our Customer Service Department for assistance.

Residential Treatment Facility (Alcoholism and Substance Abuse)
This is an institution that meets all of the following requirements:

- ☐ On-site licensed Behavioral Health Provider 24 hours per day/7 days a week.
- ☐ Provides a comprehensive patient assessment (preferably before admission, but at least upon

admission).

- ☐ Is admitted by a Physician.
- ☐ Has access to necessary medical services 24 hours per day/7 days a week.
- ☐ If the member requires Detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending Physician.
- ☐ Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- ☐ Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- ☐ Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- ☐ Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy.
- ☐ Has peer-oriented activities.
- ☐ Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the Cigna credentialing criteria as an individual Behavioral Health Practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- ☐ Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- ☐ Provides a level of skilled intervention consistent with patient risk.
- ☐ Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- ☐ Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- ☐ Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- ☐ 24-hours per day/7 days a week supervision by a Physician with evidence of close and frequent observation.
- ☐ On-site, licensed Behavioral Health Provider, medical or Substance Abuse professionals 24 hours per day/7 days a week.

Residential Treatment Facility (Mental Disorders)

This is an institution that meets all of the following requirements:

- ☐ On-site licensed Behavioral Health Provider 24 hours per day/7 days a week.
- ☐ Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- ☐ Is admitted by a Physician.
- ☐ Has access to necessary medical services 24 hours per day/7 days a week.
- ☐ Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- ☐ Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- ☐ Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- ☐ Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual

psychotherapy.

- ☐ Has peer-oriented activities.
- ☐ Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the Cigna credentialing criteria as an individual Behavioral Health Practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- ☐ Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- ☐ Provides a level of skilled intervention consistent with patient risk.
- ☐ Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- ☐ Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

R.N.
A registered nurse.

Room and Board
Charges made by an institution for Room and Board and other Medically Necessary services and supplies. The charges must be regularly made at a daily or weekly rate.

S

Semi-Private Room Rate
The Room and Board charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, Cigna will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area
This is the geographic area, as determined by Cigna, in which In-Network Providers for this plan are located.

Skilled Nursing Facility
An institution that meets all of the following requirements:

- ☐ It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from Illness or Injury:
  - ■ Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.; and
  - ■ Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- ☐ Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- ☐ Is supervised full-time by a Physician or an R.N.
- ☐ Keeps a complete medical record on each patient.
- ☐ Has a utilization review plan.
- ☐ Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of Mental Disorders.

- ☐ Charges patients for its services.
- ☐ An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- ☐ Qualifies as a Skilled Nursing Facility under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation Hospitals (all levels of care, e.g. acute) and portions of a Hospital designated for skilled or rehabilitation services.

Skilled Nursing Facility does not include:

- ☐ Institutions which provide only:
  - Minimal care;
  - Custodial Care services;
  - Ambulatory; or
  - Part-time care services.
- ☐ Institutions which primarily provide for the care and treatment of alcoholism, Substance Abuse or Mental Disorders.

Skilled Nursing Services

Services that meet all of the following requirements:

- ☐ The services require medical or paramedical training.
- ☐ The services are rendered by an R.N. or L.P.N. within the scope of his or her license.
- ☐ The services are not custodial.

Specialist

A Physician who practices in any generally accepted medical or surgical sub-specialty.

Spouse

Spouse must meet the definition as defined on Page 6, under *Coverage for Spouses*, in this Summary Plan Description.

Stay

A full-time inpatient confinement for which a Room and Board charge is made.

Stepchild(ren)

Stepchildren are natural or adopted children of your Spouse who have not met any of the termination requirements listed under Ohio Revised Code section 3119.88.

Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent

(These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a Mental Disorder that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Surgery Center
A freestanding ambulatory surgical facility that meets all of the following requirements:

- ☐ Meets licensing standards.
- ☐ Is set up, equipped and run to provide general surgery.
- ☐ Charges for its services.
- ☐ Is directed by a staff of Physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- ☐ Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- ☐ Extends surgical staff privileges to:
    - ■ Physicians who practice surgery in an area Hospital; and
    - ■ Dentists who perform oral surgery.
- ☐ Has at least 2 operating rooms and one recovery room.
- ☐ Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- ☐ Does not have a place for patients to Stay overnight.
- ☐ Provides, in the operating and recovery rooms, full-time Skilled Nursing Services directed by an R.N.
- ☐ Is equipped and has trained staff to handle Emergency Medical Conditions.

Must have all of the following:

- ☐ A Physician trained in cardiopulmonary resuscitation; and
- ☐ A defibrillator; and
- ☐ A tracheotomy set; and
- ☐ A blood volume expander.
- ☐ Has a written agreement with a Hospital in the area for immediate emergency transfer of patients.
- ☐ Written procedures for such a transfer must be displayed and the staff must be aware of them.
- ☐ Provides an ongoing quality assurance program. The program must include reviews by Physicians who do not own or direct the facility.
- ☐ Keeps a medical record on each patient.

T

Terminally Ill (Hospice Care)
Terminally Ill means a medical prognosis of 6 months or less to live.

U

Urgent Admission
A Hospital admission by a Physician due to:

- ☐ The onset of or change in a Illness; or
- ☐ The diagnosis of a Illness; or
- ☐ An Injury.
- ☐ The condition, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a Hospital within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider
This is:

- ☐ A freestanding medical facility that meets all of the following requirements.
  - ■ Provides unscheduled medical services to treat an Urgent Condition if the person's Physician is not reasonably available.
  - ■ Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - ■ Makes charges.
  - ■ Is licensed and certified as required by any state or federal law or regulation.
  - ■ Keeps a medical record on each patient.
  - ■ Provides an ongoing quality assurance program. This includes reviews by Physicians other than those who own or direct the facility.
  - ■ Is run by a staff of Physicians. At least one Physician must be on call at all times.
  - ■ Has a full-time administrator who is a licensed Physician.
- ☐ A Physician's office, but only one that:
  - ■ Has contracted with Cigna to provide urgent care; and
  - ■ Is, with Cigna's consent, included in the Directory as an in-network Urgent Care Provider.
- ☐ It is not the emergency room or outpatient department of a Hospital.

Urgent Condition
This means a sudden Illness; Injury; or condition; that:

- ☐ Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- ☐ Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- ☐ Does not require the level of care provided in the emergency room of a Hospital; and
- ☐ Requires immediate outpatient medical care that cannot be postponed until your Physician becomes reasonably available.

W

Walk-in Clinic

Walk-in Clinics are free-standing health care facilities. They are an alternative to a Physician's office visit for treatment of unscheduled, non-emergency Illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a Physician. Neither an emergency room, nor the outpatient department of a Hospital, shall be considered a Walk-in Clinic.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Cigna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Cigna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Cigna contact number on the back of your ID card.

If your Cigna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Cigna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider, then you do not need prior authorization from Cigna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Cigna contact number on the back of your ID card. ***Our plan does not require, but does allow you to select a PCP.***

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of Stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter Stay if the attending provider (e.g., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) Stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the Stay.

In addition, a plan or issuer may not, under federal law, require that you, your Physician, or other health care provider obtain authorization for prescribing a length of Stay of up to 48 hours (or 96 hours). However, you may be required to obtain Precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on Precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- ☐ All stages of reconstruction of the breast on which a mastectomy has been performed;
- ☐ Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ☐ Prostheses; and
- ☐ Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending Physician and the patient, and will be provided in accordance with the plan design, limitations, Copays, Deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/HealthInsReformforConsume/, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply with Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA).

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- ☐ The date you are required to make any contribution and you fail to do so.
- ☐ The date your Employer determines your approved FMLA leave is terminated.
- ☐ The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on

such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

Recognized Charge with Surprise Billing

The amount of an Out-of-Network Provider's charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

Through the National Advantage Program (NAP), the Recognized Charge is determined as follows:

- ☐ If your service was received from a NAP provider, a pre-Negotiated Charge will be paid. NAP providers are Out-of-Network Providers that have contracts with Cigna, directly or through third-party vendors, that include a pre-Negotiated Charge for services. NAP providers are not network providers.
- ☐ If your service was not received from a NAP provider, a claim specific rate or discount may be negotiated by Cigna or a third-party vendor.

If your claim is not paid as outlined above, the Recognized Charge for specific services or supplies will be the out-of-network plan rate, calculated in accordance with the following:

Service or Supply	Out-of-Network Plan Rate
Professional services	An amount determined by Cigna, or its third-party vendors, based on data resources selected by Cigna, reflecting typical costs, competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided.

Inpatient and outpatient charges of Hospitals	An amount determined by Cigna (such as FCR), or its third-party vendors, based on data resources selected by Cigna, reflecting typical costs, competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided.
Inpatient and outpatient charges of facilities other than Hospitals	Facility Charge Review
Prescription drugs	110% of the average wholesale price (AWP)

Important note: If the provider bills less than the amount calculated using the out-of-network plan rate described above, the Recognized Charge is what the provider bills.

In the event you receive a balance bill from a provider for your Out-of-Network Service, Patient Advocacy Services may be available to assist you in certain circumstances.

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- ☐ Performed at an in-network facility by certain Out-of-Network Providers
- ☐ Not available from an In-Network Provider
- ☐ Emergency services

We will calculate your cost share for involuntary services in the same way as we would if you received the services from an In-Network Provider. If you receive a surprise bill, your cost share will be calculated at the median contracted rate.

Important Note:
In the case of a surprise bill from an Out-of-Network Provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from an In-Network Provider. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.

Special terms used:

- ☐ Average wholesale price (AWP) is the current average wholesale price of a prescription drug listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by Cigna).
- ☐ Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility provider's estimated costs for the service and leave the facility provider with a reasonable profit. For Hospitals and other facilities that report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on what the facilities report to CMS. For facilities that do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. We may adjust the formula as needed to maintain the reasonableness of the Recognized Charge. For example, we may make an adjustment if we determine that in a particular state the charges of ambulatory Surgery Centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.
- ☐ Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

Our reimbursement policies
We reserve the right to apply our reimbursement policies to all Out-of-Network Services including involuntary services. Our reimbursement policies may affect the Recognized Charge.

These policies consider:

- ☐ The duration and complexity of a service
- ☐ When multiple procedures are billed at the same time, whether additional overhead is required
- ☐ Whether an assistant surgeon is necessary for the service
- ☐ If follow-up care is included
- ☐ Whether other characteristics modify or make a particular service unique
- ☐ When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- ☐ The educational level, licensure or length of training of the provider

Our reimbursement policies may consider:

- ☐ The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- ☐ Generally accepted standards of medical and dental practice
- ☐ The views of **Physicians** and Dentists practicing in the relevant clinical areas
- ☐ Cigna's own data and/or databases and methodologies maintained by third parties.

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits
We have online tools to help you decide where to get care. Use the "Estimate the Cost of Care" tool on Cigna member website. Cigna's secure member website at www.Cigna.com may contain additional information that can help you determine the cost of a service or supply. Log on to Cigna member website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools.

Emergency services important note:

- ☐ Out-of-Network Providers do not have a contract with us. The provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by the plan. If the provider bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the provider. Make sure the member ID is on the bill.
- ☐ In the case of a surprise bill from an Out-of-Network Provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from an In-Network Provider. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.
- ☐ If you are admitted to the Hospital for an inpatient Stay right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient Hospital cost share, if any.

Emergency services
When you experience an Emergency Medical Condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and Ambulance help.

Your coverage for emergency services will continue until your condition is stabilized and:

- ☐ Your attending Physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care
- ☐ You are in a condition to be able to receive from the Out-of-Network Provider delivering services the notice and consent criteria with respect to the services
- ☐ Your Out-of-Network Provider delivering the services meets the notice and consent criteria with respect to the services

If your Physician decides you need to Stay in the Hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. Please refer to the *How your plan works – Medical Necessity and Precertification requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your in-network Physician or Primary Care Physician (PCP).

Non-Emergency Services
If you go to an emergency room for what is not an Emergency Medical Condition, the plan may not cover your expenses. See the Schedule of Benefits section for more information.

Schedule of Benefits

	LOW -DED +INCENTIVE		LOW -DED NON- INCENTIVE		HIGH DEDUCTIBLE	
Plan Features	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Calendar Year Deductible*						
Individual Deductible*	$500	$1,000	$1,000	$1,500	$1,800	$1,800
Family Deductible*	$1,000	$2,000	$2,000	$3,000	$3,600 (*with $3,200 individual Deductible*)	$3,600 (*with $3,200 individual Deductible*)
Lifetime Maximum Benefit per person	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

Unless otherwise indicated, any applicable **Deductible must be met before benefits are paid.*

Plan Maximum Out of Pocket Limit includes plan **Deductible**.

	LOW -DED +INCENTIVE		LOW -DED NON- INCENTIVE		HIGH DEDUCTIBLE	
Plan Features	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Individual Maximum Out of Pocket Limit	For in-network expenses: $1,500	For out-of-network expenses: $3,000	For in-network expenses: $3,000	For out-of-network expenses: $4,500	For in-network expenses: $5,000	For out-of-network expenses: $10,000
Family Maximum Out of Pocket Limit	For in-network expenses: $3,000	For out-of-network expenses: $6,000	For in-network expenses: $6,000	For out-of-network expenses: $9,000	For in-network expenses: $10,000	For out-of-network expenses: $20,000

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any Deductibles and the remaining Payment Percentage. You are responsible for full payment of any non-Covered Expenses you incur.

All Covered Expenses are subject to the Calendar Year Deductible unless otherwise noted in the Schedule below.

Maximums for specific Covered Expenses, including visit, day and dollar maximums are combined maximums between in-network and out-of-network, unless specifically stated otherwise.

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
PREVENTIVE CARE BENEFITS						
Routine Physical Exams Includes coverage for immunizations	100% per visit No Copay or Deductible applies	60% per visit after Calendar Year Deductible	100% per visit No Copay or Deductible applies	60% per visit after Calendar Year Deductible	100% per visit No Deductible applies	65% per visit after Calendar Year Deductible
Maximum Exams per 12 consecutive month period						
Adults age 18 and over	1 exam	1 exam	1 exam	1 exam	1 exam	1 exam
Well Child Exams Includes coverage for immunizations	100% per visit No Copay or Deductible applies	60% per visit after Calendar Year Deductible	100% per visit No Copay or Deductible applies	60% per visit after Calendar Year Deductible	100% per visit No Copay or Deductible applies	65% per visit after Calendar Year Deductible
Maximum Exams						
Under age 3						
first 12 months of life	7 exams	7 exams	7 exams	7 exams	7 exams	7 exams
13th-36th months of life	3 exams	3 exams	3 exams	3 exams	3 exams	3 exams
For age 3 to 18	1 exam	1 exam	1 exam	1 exam	1 exam	1 exam
Hearing Exam	$40 per exam Copay then the plan pays 100% - No Calendar Year Deductible applies	60% per exam after Calendar Year Deductible	$80 per exam Copay then the plan pays 100% - No Calendar Year Deductible applies	60% per exam after Calendar Year Deductible	85% per exam after Calendar Year Deductible	65% per exam after Calendar Year Deductible
Maximum exams per 24 month period	1 exam	1 exam	1 exam	1 exam	1 exam	1 exam
ROUTINE CANCER SCREENINGS						
Routine Gynecological Exam (Includes Routine Pap Smears)	100% per exam No Calendar Year Deductible applies.	60% per exam after Calendar Year Deductible	100% per exam No Calendar Year Deductible applies.	60% per exam after Calendar Year Deductible	100% per exam No Calendar Year Deductible applies.	65% per exam after Calendar Year Deductible

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Maximum exams per Calendar Year	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your Physician, log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your Physician, log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your Physician, log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your Physician, log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your Physician, log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your Physician, log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.*
All Other Routine Exams and Screenings	100% per exam No Calendar Year Deductible applies.	60% per exam after Calendar Year Deductible	100% per exam No Calendar Year Deductible applies.	60% per exam after Calendar Year Deductible	100% per exam No Calendar Year Deductible applies.	65% per exam after Calendar Year Deductible
Maximum tests per Calendar Year	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
	For details, contact your Physician, [log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.]	*For details, contact your Physician, [log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.]*	*For details, contact your Physician, [log onto the Cigna website www.Cigna.com, or or call the number on the back of your ID card.]*	*For details, contact your Physician, [log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.]*	*For details, contact your Physician, [log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.]*	*For details, contact your Physician, [log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.]*
PHYSICIAN SERVICES						
Office Visits to Primary Care Physician Office visits (non-surgical) to Non-Specialist (including Chiropractic, up to 20 visits per year)	$20 visit Copay then the plan pays 100% No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	$40 visit Copay then the plan pays 100% No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Telehealth with MDLIVE Primary Care Services	$10 visit Copay then the plan pays 100% No Calendar Year Deductible applies	Not covered	$20 visit Copay then the plan pays 100% No Calendar Year Deductible applies	Not covered	85% per visit after Calendar Year Deductible	Not covered
Specialist Office Visits	$40 visit Copay then the plan pays 100% No Calendar Year Deductible applies.	60% per visit after Calendar Year Deductible	$80 visit Copay then the plan pays 100% No Calendar Year Deductible applies.	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Telehealth with MDLIVE Specialty Care Services	$20 visit Copay then the plan pays 100% No Calendar Year Deductible applies	Not covered	$40 visit Copay then the plan pays 100% No Calendar Year Deductible applies	Not covered	85% per visit after Calendar Year Deductible	Not covered
Physician Office Visits-Surgery	80% per visit after Calendar Year Deductible	60% per visit after Calendar Year Deductible	70% per visit after Calendar Year Deductible	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Walk-in Clinics Non-Emergency Visit	$20 visit Copay then the plan pays 100%	60% per visit after Calendar Year Deductible	$40 visit Copay then the plan pays 100%	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
	No Calendar Year Deductible applies.		No Calendar Year Deductible applies.			
Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year Deductible	60% per visit after Calendar Year Deductible	70% per visit after Calendar Year Deductible	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Administration of Anesthesia	80% per procedure after Calendar Year Deductible	60% per procedure after Calendar Year Deductible	70% per procedure after Calendar Year Deductible	60% per procedure after Calendar Year Deductible	85% per procedure after Calendar Year Deductible	65% per procedure after Calendar Year Deductible
Allergy Testing	$40 visit Copay then the plan pays 100% No Calendar Year Deductible applies.	60% per visit after Calendar Year Deductible	$80 visit Copay then the plan pays 100% No Calendar Year Deductible applies.	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Allergy Injections and Treatment	80% per visit No Calendar Year Deductible applies.	60% per visit No Calendar Year Deductible applies.	70% per visit No Calendar Year Deductible applies.	60% per visit No Calendar Year Deductible applies.	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Immunizations (when not part of the physical exam)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Prenatal Visits	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Hearing Related Services $2,000 limit every 3 years per member	80% per visit after Calendar Year Deductible	60% per visit after Calendar Year Deductible	70% per visit after Calendar Year Deductible	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible

LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
EMERGENCY MEDICAL SERVICES					
Hospital Emergency Facility and Physician	$150 Copay per visit then the plan pays 100% No Calendar Year Deductible applies.	$150 Deductible per visit then the plan pays 100% No Calendar Year Deductible applies.	$300 Copay per visit then the plan pays 100% No Calendar Year Deductible applies.	$300 Deductible per visit then the plan pays 100% No Calendar Year Deductible applies.	85% per visit after the Calendar year Deductible	85% per visit after the Calendar year Deductible
Important Note: Please note that some providers are not network providers and do not have a contract with Cigna, the provider may not accept payment of your cost share (your Deductible and Payment Percentage), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or Physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.					
Important Notice: A separate Hospital emergency room Deductible or Copay applies for each visit to an emergency room for Emergency Care. If you are admitted to a Hospital as an inpatient immediately following a visit to an emergency room, your Copay is waived but you will be subject to any inpatient Deductibles and Payment Percentages for your inpatient Stay. (This notice does not apply to the High Deductible Plan.)					
URGENT CARE SERVICES					
Urgent Medical Care *(at a non-Hospital free standing facility)*	$20 Copay per visit then the plan pays 100% No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	$40 Copay per visit then the plan pays 100% No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Urgent Medical Care *(from other than a non-Hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above	Refer to *Emergency Medical Services* and *Physician Services* above	Refer to *Emergency Medical Services* and *Physician Services* above	Refer to *Emergency Medical Services* and *Physician Services* above	Refer to *Emergency Medical Services* and *Physician Services* above	Refer to *Emergency Medical Services* and *Physician Services* above
Telehealth with MDLIVE Urgent Virtual Care Services	Plan pays 100%	Not covered	Plan pays 100%	Not covered	Plan pays 85% after Calendar Year Deductible	Not covered
OUTPATIENT DIAGNOSTIC AND PREOPERATIVE TESTING						
Complex Imaging	80% per procedure after Calendar Year Deductible	60% per procedure after Calendar Year Deductible	70% per procedure after Calendar Year Deductible	60% per procedure after Calendar Year Deductible	85% per procedure after Calendar Year Deductible	65% per procedure after Calendar Year Deductible
Diagnostic Laboratory Testing	$40 per visit Copay per procedure then the plan pays 100%	60% per procedure after Calendar Year Deductible	$80 per visit Copay per procedure then the plan pays 100%	60% per procedure after Calendar Year Deductible	85% per procedure after Calendar Year Deductible	65% per procedure after Calendar Year Deductible

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
	No Calendar Year Deductible applies.		No Calendar Year Deductible applies.			
Important Note: If you have your lab work done by the Wayne County Wellness Nurse, you may not be subject to the Copay (and for the High Deductible Plan, you may be able to save money). Contact the Wellness Nurse for more details and/or to see if your lab work will qualify for the waived Copay!						
Diagnostic X-Rays (except complex imaging services)	80% per procedure after Calendar Year Deductible	60% per procedure after Calendar Year Deductible	70% per procedure after Calendar Year Deductible	60% per procedure after Calendar Year Deductible	85% per procedure after Calendar Year Deductible	65% per procedure after Calendar Year Deductible
OUTPATIENT SURGERY						
Outpatient Surgery	80% per visit/surgical procedure after Calendar Year Deductible	60% per visit/surgical procedure after Calendar Year Deductible	70% per visit/surgical procedure after Calendar Year Deductible	60% per visit/surgical procedure after Calendar Year Deductible	85% per visit/surgical procedure after Calendar Year Deductible	65% per visit/surgical procedure after Calendar Year Deductible
INPATIENT FACILITY EXPENSES						
Hospital Facility Expenses Room and Board (including maternity)	80% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	70% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	85% per admission after Calendar Year Deductible	65% per admission after Calendar Year Deductible
Other than Room and Board	80% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	70% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	85% per admission after Calendar Year Deductible	65% per admission after Calendar Year Deductible
Skilled Nursing Inpatient Facility	80% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	70% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	85% per admission after Calendar Year Deductible	65% per admission after Calendar Year Deductible
Maximum Days per Calendar Year	180 days	180 days	180 days	180 days	180 days	180 days
SPECIALTY BENEFITS						
Home Health Care (Outpatient)	80% per visit after the Calendar Year Deductible	60% per visit after the Calendar Year Deductible	70% per visit after the Calendar Year Deductible	60% per visit after the Calendar Year Deductible	85% per visit after the Calendar Year Deductible	65% per visit after the Calendar Year Deductible
Maximum Visits per Calendar Year	30 visits	30 visits	30 visits	30 visits	30 visits	30 visits

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
HOSPICE BENEFITS						
Hospice Care - Facility Expenses (Room & Board)	100% per admission No Calendar Year Deductible applies	100% per admission No Calendar Year Deductible applies	100% per admission No Calendar Year Deductible applies	100% per admission No Calendar Year Deductible applies	85% per admission after the Calendar Year Deductible	65% per admission after the Calendar Year Deductible
Hospice Care - Other Expenses during a Stay	100% per admission No Calendar Year Deductible applies	100% per admission No Calendar Year Deductible applies	100% per admission No Calendar Year Deductible applies	100% per admission No Calendar Year Deductible applies	85% per admission after the Calendar Year Deductible	65% per admission after the Calendar Year Deductible
Maximum Benefit per lifetime*	360 days	360 days	360 days	360 days	360 days	360 days
**Lifetime maximum is a combined maximum for inpatient and outpatient services.*						
Hospice Outpatient Visits	100% per visit No Calendar Year Deductible applies	100% per visit No Calendar Year Deductible applies	100% per visit No Calendar Year Deductible applies	100% per visit No Calendar Year Deductible applies	85% per visit after the Calendar Year Deductible	65% per visit after the Calendar Year Deductible

INFERTILITY TREATMENT						
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the under-lying medical condition causing the Infertility only	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

MENTAL DISORDERS						
Office Visits (non-surgical)	$20 visit Copay then the plan pays 100%; No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	$40 visit Copay then the plan pays 100%; No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Inpatient Treatment	80% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	70% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	85% per admission after the Calendar Year Deductible	65% per admission after the Calendar Year Deductible

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Maximum Benefit per Calendar Year	30 days	10 days	30 days	10 days	30 days	10 days
Outpatient Treatment	80% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	70% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	85% per admission after the Calendar Year Deductible	65% per admission after the Calendar Year Deductible
Maximum Visits per Calendar Year	50 visits	20 visits	50 visits	20 visits	50 visits	20 visits

Updated 1/1/19

ALCOHOLISM AND SUBSTANCE ABUSE						
Office Visits (non-surgical)	$20 visit Copay then the plan pays 100%; No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	$40 visit Copay then the plan pays 100%; No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Inpatient Treatment	80% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	70% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	85% per admission after the Calendar Year Deductible	65% per admission after the Calendar Year Deductible
Maximum Days per Calendar Year	30 days	10 days	30 days	10 days	30 days	10 days
Lifetime Maximum	2 courses of treatment		2 courses of treatment		2 courses of treatment	
Outpatient Treatment	80% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	70% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	85% per admission after the Calendar Year Deductible	65% per admission after the Calendar Year Deductible
Maximum Visits per Calendar Year	50 visits	20 visits	50 visits	20 visits	50 visits	20 visits
Important Notice: Both in-network and out-of-network alcoholism and Substance Abuse and mental Illness treatment visit limits accumulate toward any maximum shown above for alcoholism and Substance Abuse and mental Illness treatment visit limits.						

Updated 1/1/19

TRANSPLANT SERVICES FACILITY AND NON-FACILITY EXPENSES									
	Network (IOE Facility)	**Network (Non-IOE Facility)**	**Out-of-Network**	**Network (IOE Facility)**	**Network (Non-IOE Facility)**	**Out-of-Network**	**Network (IOE Facility)**	**Network (Non-IOE Facility)**	**Out-of-Network**
Transplant Facility Expenses	100% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	100% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	85% per admission after Calendar Year Deductible	65% per admission after Calendar Year Deductible	65% per admission after Calendar Year Deductible

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
OTHER COVERED HEALTH EXPENSES						
Ground, Air or Water Ambulance	80% after Calendar Year Deductible	80% after Calendar Year Deductible	70% after Calendar Year Deductible	70% after Calendar Year Deductible	85% after Calendar Year Deductible	85% after Calendar Year Deductible
Durable Medical and/or Surgical Equipment	80% per item after the Calendar Year Deductible	Not covered	70% per item after the Calendar Year Deductible	Not covered	85% per item after the Calendar Year Deductible	Not covered
Gene-based Cellular and Other Innovative Therapies (GCIT)	$100 Copay per visit; Plan pays 80% after Deductible	Not covered outside of approved clinic.	$100 Copay per visit; Plan pays 80% after Deductible	Not covered outside of approved clinic.		
Jaw Joint Disorder Treatment	80% per visit after Calendar Year Deductible* *if not part of an office visit	60% per visit after Calendar Year Deductible	70% per visit after Calendar Year Deductible* *if not part of an office visit	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
OUTPATIENT THERAPIES						
Chemo-therapy	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
Renal Replacement Therapy (RRT) / Dialysis	Covered same as plan's Outpatient Facility Services benefit	Covered same as plan's Outpatient Facility Services benefit	Covered same as plan's Outpatient Facility Services benefit	Covered same as plan's Outpatient Facility Services benefit	Covered same as plan's Outpatient Facility Services benefit	Covered same as plan's Outpatient Facility Services benefit
SHORT TERM OUTPATIENT REHABILITATION THERAPIES						
Outpatient Physical and Occupational Therapy only	$40 per day Copay then the plan pays 100% No Calendar Year Deductible applies	60% per day after Calendar Year Deductible	$80 per day Copay then the plan pays 100% No Calendar Year Deductible applies	60% per day after Calendar Year Deductible	85% per day after Calendar Year Deductible	65% per day after Calendar Year Deductible
Physical Therapy Maximum visits per Calendar Year	30 visits	30 visits	30 visits	30 visits	30 visits	30 visits
Occupational Therapy Maximum visits per Calendar Year	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
Speech Therapy only	$40 per day Copay then the plan pays 100%	60% per day after Calendar Year Deductible	$80 per day Copay then the plan pays 100%	60% per day after Calendar Year Deductible	85% per day after Calendar Year Deductible	65% per day after Calendar Year Deductible

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
	No Calendar Year Deductible applies		No Calendar Year Deductible applies			
Speech Therapy Maximum visits per Calendar Year	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits

SPINAL MANIPULATION						
Spinal Manipulation only	$40 per visit Copay then the plan pays 100% No Calendar Year Deductible applies.	60% per visit after Calendar Year Deductible	$80 per visit Copay then the plan pays 100% No Calendar Year Deductible applies.	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
Important Notice: Both **in-network** and **out-of-network** Short Term Outpatient Rehabilitation Therapies visit limits accumulate toward any maximum shown above for Short Term Outpatient Rehabilitation Therapies visit limits.						
Updated 10/7/2022						

Expense Provisions

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this Schedule of Benefits.

This Schedule of Benefits replaces any Schedule of Benefits previously in effect under your plan of health benefits.

Deductible Provisions

In-Network Calendar Year Deductible

This is an amount of in-network Covered Expenses incurred each Calendar Year for which no benefits will be paid. The in-network Calendar Year Deductible applies separately to you and each of your covered dependents. After Covered Expenses reach the in-network Calendar Year Deductible, the plan will begin to pay benefits for Covered Expenses for the rest of the Calendar Year.

Out-of-Network Calendar Year Deductible

This is an amount of out-of-network Covered Expenses incurred each Calendar Year for which no benefits will be paid. The out-of-network Calendar Year Deductible applies separately to you and each of your covered dependents. After Covered Expenses reach the out-of-network Calendar Year Deductible, the plan will begin to pay benefits for Covered Expenses for the rest of the Calendar Year.

Covered Expenses applied to the out-of-network Deductible will not be applied to satisfy the in-network Deductible and Covered Expenses applied to the in-network Deductible will not be applied to satisfy the out-of-network Deductible.

In-Network Family Deductible Limit

When you incur in-network Covered Expenses that apply toward the in-network Calendar Year Deductibles for you and each of your covered dependents, these expenses will also count toward the in-network Calendar Year family Deductible limit. Your in-network family Deductible limit will be considered to be met for the rest of the Calendar Year once the combined Covered Expenses reach the in-network family Deductible limit in a Calendar Year.

Out-of-Network Family Deductible Limit

When you incur out-of-network Covered Expenses that apply toward the out-of-network Calendar Year Deductibles for you and each of your covered dependents, these expenses will also count toward the out-of-network Calendar Year family Deductible limit. Your out-of-network family Deductible limit will be considered to be met for the rest of the Calendar Year once the combined Covered Expenses reach the out-of-network family Deductible limit in a Calendar Year.

Covered Expenses applied to the out-of-network Deductible will not be applied to satisfy the in-network Deductible and Covered Expenses applied to the in-network Deductible will not be applied to satisfy the out-of-network Deductible.

Copayments and Benefit Deductible Provisions (does not apply to High Deductible Plan)

This is a specified dollar amount or percentage of the Negotiated Charge required to be paid by you at the time you receive a covered service from an In-Network Provider. It represents a portion of the applicable expense.

Payment Percentage

This is both the percentage of Covered Expenses that the plan pays, and the percentage of Covered Expenses that you pay. Once applicable Deductibles have been met, your plan will pay a percentage of the Covered Expenses, and you will be responsible for the rest of the costs. The percentage that the plan pays may vary by the type of expense. The percentage that you pay is also known as “Co-Insurance”. Please refer to this Schedule of Benefits section for specific information on Payment Percentage amounts for each covered benefit.

Maximum Out-of-Pocket Limit

The Maximum Out-of-Pocket Limit is the maximum amount you are responsible to pay for Covered Expenses during the Calendar Year. Once you satisfy the Maximum Out-of-Pocket Limit, the plan will pay 100% of the Covered Expenses that apply toward the limit for the rest of the Calendar Year. The Maximum Out-of-Pocket Limit applies to both in-network and out-of-network benefits.

This plan has an Individual Maximum Out-of-Pocket Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual Maximum Out-of-Pocket Limit, the plan will pay 100% of Covered Expenses for the remainder of the Calendar Year for that person.

There is also a Family Maximum Out-of-Pocket Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets two times the individual Maximum Out-of-Pocket Limit, the plan will pay 100% of Covered Expenses for the remainder of the Calendar Year for all covered family members.

The Maximum Out-of-Pocket Limit applies to both in-network and out-of-network benefits. You have separate Maximum Out-of-Pocket Limits for in-network and out-of-network benefits. Maximum Out-of-Pocket Limit amounts paid by you for in-network and out-of-network Covered Expenses apply to each limit separately and may not be combined and applied toward one limit.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain Covered Expenses do not apply toward your plan out-of-pocket limit. These include:

- ☐ Charges over the Recognized Charge;
- ☐ Expenses incurred for outpatient prescription drugs (this bullet does not apply to High Deductible Plan);
- ☐ Non-Covered Expenses;
- ☐ Expenses that are not paid, or Precertification benefit reductions because a required Precertification for the service(s) or supply was not obtained from Cigna.

Calendar Year Maximum Benefit

The most the plan will pay for Covered Expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit. The Calendar Year maximum benefit applies to in-network care and out-of-network care expenses combined.

Precertification Benefit Reduction

The SPD contains a complete description of the Precertification program. Refer to the Understanding Precertification section for a list of services and supplies that require Precertification. Failure to Precertify your Covered Expenses when required will result in a benefits reduction as follows:

- ☐ A $500 benefit reduction will be applied separately to each type of expense.

Time Frame to Turn in Claims

All claims must be turned into Cigna for processing within 12 months of the service date. Claims turned in after 12 months from the date of service will not be paid nor considered covered services.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your SPD and should be kept with your SPD.

Important Notices:

- Review the Summary of Benefit Coverage behind tab 10 of this binder for a recap of the Wayne County Plan design and coverage examples.
- Read more about the Wellness Program in the Notice Regarding Wellness Program behind tab 10 and in the Wellness Program section of this binder