Metropolitan Nashville and Davidson County
Employee Benefit Board

CIGNA CHOICE FUND
MEDICAL HRA PLAN

Group Number: 3172416

Effective January 1, 2019

Table of Contents

ABOUT THIS DOCUMENT

This document is the official Plan document of the Metropolitan Government of Nashville & Davidson County CIGNA Choice Fund Open Access Plus Medical Plan (the "Plan"). If there is a difference between this Plan and other plan documents that describe the Plan, this document will govern.

References in this Plan to the "Administrator" mean Cigna. The pronouns "we," "us," and "our" used throughout this Plan refer to Cigna. The Metropolitan Government of Nashville & Davidson County ("Metro") through the Employee Benefit Board (the "Board") has entered into an Administrative Services Agreement (ASA) with Cigna for it to administer the claims payments under the terms of the Plan, and to provide other services. Cigna is not the Plan Sponsor, the Plan Administrator or the Plan Fiduciary. Metro and the Board are the Plan Fiduciary, the Plan Sponsor and the Plan Administrator. Other federal laws may also affect your coverage. To the extent applicable, the Plan complies with federal requirements.

This Plan describes the terms and conditions of your Coverage through the Plan. It replaces and supersedes any Certificate or other description of benefits you have previously received from the Plan.

Please read this Plan carefully. It describes your rights and duties as a Member. It is important to read the entire Plan. Certain services are not covered by the plan. Other Covered Services are or may be limited. The Plan will not pay for any service not specifically listed as a Covered Service, even if a health care provider recommends or orders that non-covered benefit.

While the Board has delegated discretionary authority to make any benefit or eligibility determinations to the Administrator, the Board retains the authority to make any final determination. The Board, as the Plan Administrator, also has the authority to construe the terms of your coverage.

Any grievance related to your Coverage under this Plan shall be resolved in accordance with the "Grievance Procedure" Section VI of this Plan.

Some terms contained in this document are defined terms. Please review the definition of terms section of this Plan or other sections that contain defined terms of the Plan.

Please contact one of the Administrator's Customer Service Representatives, at the number listed on your ID card, if you have any questions when reading this Plan. The Customer Service Representatives are also available to discuss any other matters related to your Coverage through the Plan.

Metro Nashville Government believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any

cost sharing. However, grandfathered plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential benefits. Annual and lifetime limits continue to apply to custom built shoes.

Questions regarding which protections apply and which protections do not apply to a grandfathered plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Metro Human Resources (615) 862-6640. You may also contact the U.S. Department of Health and Human Services at *www.healthreform.gov*.

RELATIONSHIP WITH NETWORK PROVIDERS

Independent Contractors

Network Providers are not Employees, agents or representatives of the Administrator. Such Providers contract with the Administrator, which has agreed to pay them for rendering Covered Services to Members. Network Providers are solely responsible for making all medical treatment decisions in consultation with their Member-patients. The Administrator does not make medical treatment decisions under any circumstances.

While the Administrator has the authority to make benefit and eligibility determinations and interpret the terms of your Coverage, the Board, as the Plan Administrator has the discretionary authority to make the final determination regarding the terms of your Coverage ("Coverage Decisions"). Both the Administrator and the Board make Coverage Decisions based on the terms of this Plan, the ASA, the Administrator's Participation Agreements with Network Providers, and applicable State or Federal laws.

The Administrator's Participation Agreements permit Network Providers to dispute Coverage Decisions if they disagree with those Decisions. If your Network Provider does not dispute a Coverage Decision, you may request reconsideration of that Decision as explained in the Grievance Procedure section of this Plan. The Participation Agreement requires Network Providers to explain fully and fairly Coverage Decisions to you, upon request, if you decide to request that the Administrator reconsider a Coverage Decision.

The Administrator has established various incentive arrangements to encourage Network Providers to provide Covered Services to you in an appropriate and cost effective manner. You may request information about your Provider's Payment arrangement by contacting the Administrator's Customer Service Department.

Termination of Providers' Participation

The Administrator or a Network Provider may end their relationship with each other at any time. A Network Provider may also limit the number of Members that he, she or it will accept as patients during the term of this Agreement. The Administrator does not promise that any specific Network Provider will be available to render services while you are covered.

OTHER METRO MEDICAL BENEFITS

Metro offers additional medical options other than the benefits described in this Plan. Specifically, Metro also offers the BlueCross BlueShield PPO Plan as an option and additionally, the Humana Plan for Medicare eligible pensioners. Other medical coverage options are not discussed in this Plan.

SECTION I – SCHEDULE OF BENEFITS

BENEFITS AVAILABLE

A Member is entitled to benefits for Covered Services as specified in this Schedule of Benefits. Benefits shall be determined according to the plan terms in effect when a service is received. Benefits may be amended at any time in accordance with applicable provisions of the ASA. Under no circumstance does a Member acquire a vested interest in continued receipt of a particular benefit or level of benefit.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

The Cigna Choice Fund® is a Health Reimbursement Arrangement where traditional medical coverage is combined with a Fund of contributions made by Metro. The HRA Fund can be used to pay for qualified health care and pharmacy expenses during the plan year. Amounts paid by the HRA Fund for Covered Services count toward the annual deductible. Preventative services are covered at 100% and do not apply against the HRA Fund.

Metro will contribute:

- $1,100 for Individual Coverage
- $2,200 for Family Coverage
- $2,200 for Employee + Child(ren) Coverage (coverage tier available to employees with one or more Dependent Child; plan funds and maximums are the same as Family Coverage tier)

NOTE: If you have elected one of the following Coverages and therefore, have Medicare Parts A and B paying primary for your medical coverage, you will **NOT** receive the HRA Fund contribution by Metro (eligible domestic partners qualify for the spouse coverage level):

- Pensioner with Medicare
- Pensioner with Medicare, Spouse without
- Pensioner and Spouse both with Medicare
- Pensioner with Medicare and Child(ren) with or without Medicare
- Pensioner, Spouse and Child(ren) all with Medicare
- Three Family Members Covered with Two of them having Medicare Parts A and B (if the Pensioner is one of the two members with Medicare Parts A and B).

DEDUCTIBLE
Once Metro's contributions to the HRA Fund have been exhausted, there is a deductible that must be met. Participation in the Incentive Programs will lower your deductible. The deductible is:

- $450 for Individual Coverage
- $900 for Family Coverage (covers the Spouse/Domestic Partner and any other eligible dependent)
- $900 for Employee + Child(ren) Coverage (covers the Employee and one or more eligible dependent child(ren). Plan funds and maximums are the same as Family Coverage tier)

After the deductible is met, you enter the Co-insurance portion of the Cigna Choice Fund and you use a traditional medical plan for Covered Services up to your out-of-pocket maximum.

If at the end of the plan year, the HRA Fund has contributions remaining, the HRA Fund balance will roll over to the next plan year thereby lowering your deductible portion.

PRORATED HRA FUND AND DEDUCTIBLE
If you become enrolled with a coverage Effective Date April 1 or later, your HRA Fund and deductible will be prorated based upon the quarter in which your coverage becomes effective.

If during the same year that your coverage becomes effective, you add a Dependent as a result of an eligible change in status, the HRA Fund and Deductible will be increased as if you had Family or Employee + Child(ren) coverage on your insurance Effective Date. If you change from Family or Employee + Child(ren) coverage to individual coverage at any point during the year, the HRA Fund and deductible will not be decreased or prorated.

The HRA Fund and Deductible will be prorated as follows:

Insurance Effective Date Occurs in	Individual Coverage	Family Coverage or Employee + Child(ren) Coverage
1st Quarter January – February – March	$1,100 HRA Fund $450 Deductible	$2,200 HRA Fund $900 Deductible
2nd Quarter April – May – June	$825 HRA Fund $450 Deductible	$1,650 HRA Fund $900 Deductible
3rd Quarter July – August – September	$550 HRA Fund $450 Deductible	$1,100 HRA Fund $900 Deductible
4th Quarter October – November – December	$275 HRA Fund $450 Deductible	$550 HRA Fund $900 Deductible

CALCULATION CO-INSURANCE AND OUT-OF-POCKET MAXIMUM

As part of the efforts to contain health care costs, Cigna has negotiated agreements with Hospitals and other Providers under which Cigna receives a discount on Hospital and other Provider bills. In addition to such discounts, Cigna also has some agreements with Hospitals and other Providers under which payment is based upon other methods of payment (such as flat rates, capitation or per diem amounts).

After meeting your deductible, your Co-insurance will be based upon the same dollar amount of payment that Cigna uses to calculate its portion of the claims payment to the Hospital or other Providers.

Co-insurance To Be Applied To:	Network Provider	Non-Network Provider
All Covered Services after Deductible has been satisfied (unless otherwise specified)	90%	70%
Preventive Services	Covered at 100%	70%

INCENTIVE PROGRAMS

The CIGNA Choice Fund offers you four programs to earn incentive dollars that are added to your HRA Fund by Metro if you choose to participate and complete a program. Only employees, pensioners and their spouses/domestic partners who are covered under the Plan are eligible to earn incentive dollars. Participation in the programs is optional and you are eligible to participate in the programs each calendar year.

1. Health Risk Assessment (online health questionnaire)

    - $100 per person upon completion ($200 maximum per family)

2. Chronic Health Condition Support – personalized support from Cigna health coaches for chronic conditions such as (but not limited to) cardiac, diabetes and chronic obstructive pulmonary disease (COPD), asthma, depression, low back pain, osteoarthritis and weight complications.

    - $100 per person ($200 maximum per family; each person is only eligible to receive one $100 incentive under this program each calendar year)

3. Lifestyle Management Program – personalized support from Cigna health coaches for lifestyle behaviors such as tobacco cessation, stress and weight loss.

- $50 per person (You can participate in the separate programs for each behavior (tobacco, stress and weight loss) but there is a $100 annual maximum per person; $200 annual maximum per family.)

4. Healthy Pregnancies, Healthy Babies[SM]

- $150 if you enroll by the end of your first trimester, or
- $75 if you enroll by the end of your second trimester
- Participation in a program designed to help you and your baby stay healthy during your pregnancy. This program encourages you to get prenatal care early in your pregnancy. When you complete the program and after your baby is born, you will receive the incentive dollars.

MEMBER'S RESPONSIBILITY

Prior Authorization may be required for certain services. Please have your Physician contact Cigna at the telephone number shown on your identification card before services are provided. Otherwise, your benefits may be reduced or denied.

The Dependent Child Limiting Age will be to age 26.

SCHEDULE OF MEDICAL BENEFITS

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE
For You and Your Dependents
Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible or Coinsurance. If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE

Coinsurance
The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

Deductibles
Deductibles are also expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further medical deductible for the rest of that year.

Out-of -Pocket Expenses
Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the benefit plan because of any:

- Coinsurance.
- Deductibles.

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums
Deductibles and Out-of-Pocket Maximums will cross-accumulate (that is, In-Network will accumulate to Out-of-Network and Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) also cross-accumulate between In- and Out-of-Network unless otherwise noted.
Note:
Refer to your CIGNA Choice Fund Member Handbook for information about your HRA Fund benefit and how it can help you pay for expenses that may not be covered under this plan.

Multiple Surgical Reduction
Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon
The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon
The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	Unlimited
Coinsurance Levels	90% for most services	70% of the Maximum Reimbursable Charge for most services

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maximum Reimbursable Charge Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A percentage of a schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company. **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles and coinsurance. **Note:** Some providers forgive or waive the cost share obligation (e.g. your deductible and/or coinsurance) that this plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this plan. For more details, see the Exclusions Section.	Not Applicable	300%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible **(Included in the Deductible is the HRA Fund amount contributed by Metro)**	**Applies to:** • **Employees** • **Pensioners that are <u>not eligible</u> for Medicare (even if their Spouse/Domestic Partner and/or Children are)** • **Pensioners with or without Medicare who Elect Family Coverage**	
Individual Maximum	$1,550 $1,100 HRA Fund + $450 as Your Share of the Deductible	$1,550 $1,100 HRA Fund + $450 as Your Share of the Deductible
Family Maximum* *Applies to Family coverage and Employee + Child(ren) coverage. Family Maximum Calculation **Collective Deductible:** All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.	$3,100 $2,200 HRA Fund + $900 as Your Share of the Deductible	$3,100 $2,200 HRA Fund + $900 as Your Share of the Deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible	**Applies to:** ▪ **Pensioners that <u>are eligible</u> for Medicare (even if their Spouse/Domestic Partner or Children are not)** **NOTE: These coverage levels do not have a pre-funded HRA Fund, but are eligible for participation in offered incentives**	
Pensioner with Medicare Parts A and B	$450	$450
Pensioner and Spouse both with Medicare Parts A and B	$900	$900
Pensioner with Medicare Parts A and B and Spouse without	$900	$900
Pensioner with Medicare Parts A and B and Child(ren) with or without Medicare Parts A and B	$900	$900
Pensioner, Spouse and Child(ren) all with Medicare Parts A and B	$900	$900
Three Family Members Covered with Two of them having Medicare Parts A and B	$900	$900
Family Maximum Calculation **Collective Deductible:** All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Combined Medical/Pharmacy Calendar Year Deductible		
Combined Medical/Pharmacy Deductible: includes retail and home delivery drugs	Yes	Yes
Home delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Deductible	Yes	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Out-of-Pocket Maximum	**Applies to:** • **Employees** • **Pensioners that are <u>not eligible</u> for Medicare (even if their Spouse/Domestic Partner and/or Children are)** • **Pensioners with or without Medicare who Elect Family Coverage**	
Individual	$2,250 per person	$6,100 per person
	The Out-of-Pocket Maximum includes the $1,100 HRA Fund	
Family Maximum* *Applies to Family coverage and Employee + Child(ren) coverage.	$4,500 per family	$12,200 per family
	The Out-of-Pocket Maximum includes the $2,200 HRA Fund	
Family Maximum Calculation **Collective Out-of-Pocket Maximum:** All family members contribute towards the family Out-of-Pocket. An individual cannot have claims covered at 100% until the total family Out-of-Pocket has been satisfied.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Out-of-Pocket Maximum	**Applies to:** ▪ **Pensioners that <u>are eligible</u> for Medicare (even if their Spouse/Domestic Partner or Children are not)**	
Pensioner with Medicare	$1,150	$5,000
Pensioner and Spouse both with Medicare	$2,300	$10,000
Pensioner with Medicare and Spouse without	$2,300	$10,000
Pensioner with Medicare and Child(ren) with or without Medicare	$2,300	$10,000
Pensioner, Spouse and Child(ren) all with Medicare	$2,300	$10,000
Three Family Members Covered with Two of them having Medicare Parts A and B	$2,300	$10,000
Family Maximum Calculation **Collective Out-of-Pocket Maximum:** All family members contribute towards the family Out-of-Pocket. An individual cannot have claims covered at 100% until the total family Out-of-Pocket has been satisfied.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Combined Medical/Pharmacy Out-of-Pocket Maximum		
Combined Medical Pharmacy Out-of-Pocket: Includes retail and home delivery drugs	Yes	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	Yes	In-Network coverage only
Physician's Services		
Primary Care Physician's Office visit	90% after plan deductible	70% after plan deductible
Specialty Care Physician's Office Visits Consultant and Referral Physician's Services **Note:** OB-GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna.	90% after plan deductible	70% after plan deductible
Surgery Performed in the Physician's Office	90% after plan deductible	70% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	90% after plan deductible	70% after plan deductible
Allergy Treatment/Injections	90% after plan deductible	70% after plan deductible
Allergy Serum (dispensed by the physician in the office)	90% after plan deductible	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Medical Telehealth	90% after plan deductible	In-Network Coverage only
Preventive Care Note: Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit. Routine Preventive Care – all ages Immunizations – all ages	 100% (No charge to member) 100% (No charge to member)	 In-Network coverage only In-Network coverage only
Mammograms, PSA, Pap Smear Preventive Care Related Services (i.e. "routine" services) Diagnostic Related Services (i.e. "non-routine" services)	 100% (No charge to member) Subject to the plan's x-ray & lab benefit; based on place of service	 70% after plan deductible Subject to the plan's x-ray & lab benefit; based on place of service

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital - Facility Services **Semi-Private Room and Board** **Private Room** **Special Care Units (ICU/CCU)**	90% after plan deductible Limited to the semi-private room negotiated rate Limited to the semi-private room negotiated rate Limited to negotiated rate	70% after plan deductible Limited to the semi-private room negotiated rate Limited to the semi-private room negotiated rate Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room.	90% after plan deductible	70% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	90% after plan deductible	70% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	90% after plan deductible	70% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	90% after plan deductible	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Services		
Physician's Office Visit	90% after plan deductible	90% after plan deductible
Urgent Care Facility or Outpatient Facility	90% after plan deductible	90% after plan deductible
Outpatient Professional Services (radiology, pathology, physician)	90% after plan deductible	90% after plan deductible
X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit)	90% after plan deductible	90% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	90% after plan deductible	90% after plan deductible
Emergency Services		
Physician's Office Visit	90% after plan deductible	90% after plan deductible
Hospital Emergency Room	90% after plan deductible	90% after plan deductible
Outpatient Professional services (radiology, pathology and ER Physician)	90% after plan deductible	90% after plan deductible
	90% after plan deductible	90% after plan deductible
X-ray and/or Lab performed at the Emergency Room Facility (billed by the facility as part of the ER visit)	90% after plan deductible	90% after plan deductible
Independent X-ray and/or Lab Facility in conjunction with an ER visit	90% after plan deductible	90% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	90% after plan deductible	90% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Ambulance	90% after plan deductible	90% after plan deductible
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub- Acute Facilities Calendar Year Maximum: 100 days combined	90% after plan deductible	70% after plan deductible
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Outpatient Hospital Facility	90% after plan deductible	70% after plan deductible
Independent X-ray and/or Lab Facility	90% after plan deductible	70% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Office	90% after plan deductible	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: Unlimited Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	90% after plan deductible	70% after plan deductible
Chiropractic Care Calendar Year Maximum: Unlimited Physician's Office Visit	70% after plan deductible	50% after plan deductible
Acupuncture Calendar Year Maximum: $1,000 Physician's Office Visit	70% after plan deductible	50% after plan deductible
Home Health Care Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)	90% after plan deductible	70% after plan deductible
Hospice Inpatient Services Outpatient Services (same coinsurance level as Home Health Care)	90% after plan deductible 90% after plan deductible	70% after plan deductible 70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Bereavement Counseling Services provided as part of Hospice Care		
Inpatient	90% after plan deductible	70% after plan deductible
Outpatient	90% after plan deductible	70% after plan deductible
Services provided by Mental Health Professional	Covered under Mental Health Benefit	Covered under Mental Health Benefit
Maternity Care Services		
Initial Visit to Confirm Pregnancy **Note:** OB/GYN providers will be considered either a PCP or Specialist depending on how the provider contracts with Cigna.	90% after plan deductible	70% after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	90% after plan deductible	70% after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	90% after plan deductible	70% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	90% after plan deductible	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Non-Elective Termed Pregnancy Includes non-elective procedures only		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible
Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	90% after plan deductible	70% after plan deductible
Note: The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.		
Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)		
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible
Physician's Office	90% after plan deductible	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment Services Not Covered include: • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not Covered	Not Covered

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Organ Transplants Includes all medically appropriate, non-experimental transplants		
Office Visit	90% after plan deductible	70% after plan deductible
Inpatient Facility	100% at Lifesource center after plan deductible, otherwise 90% after plan deductible	70% after plan deductible
Physician's Services	100% at Lifesource center after plan deductible, otherwise 90% after plan deductible	70% after plan deductible
Lifetime Travel Maximum: $10,000 per transplant	100% (No charge to member - only available when using Lifesource facility)	In-Network coverage only
Durable Medical Equipment Calendar Year Maximum: Unlimited	90% after plan deductible	70% after plan deductible
Breast Feeding Equipment and Supplies **Note:** Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	90% after plan deductible	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
External Prosthetic Appliances Calendar Year Maximum: Unlimited	90% after plan deductible	70% after plan deductible
Orthopedic Shoes Lifetime Maximum: $1,500 Note: Custom Built Shoes...Includes repair and maintenance	90% after plan deductible	70% after plan deductible
Hearing Aids for Children Ages 17 and under Coverage is limited to one ear every three years and includes ear molds and services to select, fit and adjust hearing aids.	100% (No charge to member)	100% (No charge to member)
Nutritional Evaluation Calendar Year Maximum: 3 visits per person, however, the 3 visit limit will not apply to treatment of mental health and substance use disorder conditions.		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible
TMJ Always excludes appliances and orthodontic treatment. Subject to Medical Necessity.		
Surgical	90% after plan deductible	70% after plan deductible
Non-Surgical	70% after plan deductible	50% after plan deductible
Bariatric Surgery Note: Subject to any limitations shown in the "Exclusions" section of this document.		
Physician's Office Visit	90% after plan deductible	In-Network coverage only
Inpatient Facility	90% after plan deductible	In-Network coverage only
Outpatient Facility	90% after plan deductible	In-Network coverage only
Physician's services	90% after plan deductible	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		
Psychiatric Care and Substance Abuse Care claims incurred on and after January 1, 2010, are treated the same as any other illness.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health		
Inpatient Includes Acute Inpatient and Residential Treatment Calendar Year Maximum: Unlimited(admissions must be pre-authorized)	90% after plan deductible	70% after plan deductible
Outpatient Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, Behavioral Telehealth consultation, etc. Calendar Year Maximum: Unlimited	90% after plan deductible	70% after plan deductible
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, Behavioral Telehealth consultation, etc. Calendar Year Maximum: Unlimited	90% after plan deductible	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Substance Abuse		
Inpatient (admissions must be pre-authorized) Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Calendar Year Maximum: Unlimited	90% after plan deductible	70% after plan deductible
Outpatient Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, Behavioral Telehealth consultation, etc. Calendar Year Maximum: Unlimited	90% after plan deductible	70% after plan deductible
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, Behavioral Telehealth consultation, etc. Calendar Year Maximum: Unlimited	90% after plan deductible	70% after plan deductible

OPEN ACCESS PLUS MEDICAL BENEFITS - CERTIFICATION REQUIREMENTS – OUT-OF-NETWORK

Pre-Admission Certification and Continued Stay Review for Hospital Confinement
Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent requires treatment in a Hospital:

- as a registered bed patient; except for 48/96 hour maternity stays;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for Mental Health or Substance Abuse Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will be reduced by 50% for Hospital charges made for each separate admission to the Hospital unless (a) PAC is received: prior to the date of admission; or (b) in the case of an emergency admission, the notice described in the preceding paragraph is received by the Review Organization within 48 hours after the date of admission and subsequently approved.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

PRIOR AUTHORIZATION and PRE-AUTHORIZED

The term Prior Authorization (and pre-authorization) means the approval that a Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services; except for 48/96 hour maternity stays
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- nonemergency ambulance; or
- transplant services.

COVERED EXPENSES

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. Any applicable Deductibles or limits are shown in The Schedule.

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided or to a skilled nursing facility; provided however that transportation to: (i) the Member's or Dependent's home and (ii) another treatment or diagnostic facility other than a hospital shall be covered where it is determined to be Medically Necessary and Medically Appropriate.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.

- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives.
- office visits, tests and counseling for Family Planning services are subject to the Preventive Care Maximum shown in the Schedule.
- charges made for Routine Preventive Care including immunizations, not to exceed the maximum shown in the Schedule. Routine Preventive Care means health care assessments, wellness visits and any related services.
- surgical or nonsurgical treatment of TMJ Dysfunction.
- charges made for acupuncture.
- orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
    - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
    - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease or;
    - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.
    - Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.
- Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.
- Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

- charges for the delivery of medical and health-related consultations via secure telecommunications technologies, including telephones and internet, when delivered through a contracted medical telehealth provider.

Clinical Trials

Charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:

- the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
- the trial investigates a treatment for terminal cancer and: (1) the person has failed standard therapies for the disease; (2) cannot tolerate standard therapies for the disease; or (3) no effective nonexperimental treatment for the disease exists;
- the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol";
- the trial is approved by the Institutional Review Board of the institution administering the treatment; and
- coverage will not be extended to clinical trials conducted at nonparticipating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed herein as Exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per contract year for both pre- and postgenetic testing. The visit limit does not apply to genetic counseling related to treatment of mental health and/or substance abuse disorders.

Nutritional Evaluation
Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Internal Prosthetic/Medical Appliances
Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Home Health Services
Charges made for Home Health Services when you: (a) require skilled care; (b) are unable to obtain the required care as an ambulatory outpatient; and (c) do not require confinement in a Hospital or Other Health Care Facility.

Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or Custodial Services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or Custodial Services needs.

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

Hospice Care Services
Charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:

- by a Hospice Facility for Bed and Board and Services and Supplies;
- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, or family counselor for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies;
- by an Other Health Care Facility for:
- part-time or intermittent nursing care by or under the supervision of a Nurse;
- part-time or intermittent services of an Other Health Care Professional;
- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;

Durable Medical Equipment
Charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person’s misuse are the person’s responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.
Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not

useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- Bed Related Items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- Bath Related Items: bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- Chairs, Lifts and Standing Devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- Fixtures to Real Property: ceiling lifts and wheelchair ramps.
- Car/Van Modifications.
- Air Quality Items: room humidifiers, vaporizers, air purifiers and electrostatic machines.
- Blood/Injection Related Items provided that certain supplies for the treatment of diabetes are covered, blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- Other Equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

External Prosthetic Appliances and Devices
Charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

Prostheses/Prosthetic Appliances and Devices
Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and

- speech prostheses.

Orthoses and Orthotic Devices
Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

Nonfoot orthoses – only the following nonfoot orthoses are covered:

- rigid and semirigid custom fabricated orthoses,
- semirigid prefabricated and flexible orthoses; and
- rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.

Custom foot orthoses – custom foot orthoses are only covered as follows:

- for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
- when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
- when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
- for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces
A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints
A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear.
- Replacement for damage due to abuse or misuse by the person will not be covered.

Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Coverage for replacement is limited as follows:

- No more than once every 24 months for persons 19 years of age and older; and
- No more than once every 12 months for persons 18 years of age and under;
- Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.

Short-Term Rehabilitative Therapy
Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.
- Short-term Rehabilitative Therapy services that are not covered include but are not limited to:
- Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and

- Maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- Services that are provided by a chiropractic Physician are not covered.
- These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

Chiropractic Care Services
Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

The following limitation applies to Chiropractic Care Services:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness;
- Chiropractic Care services that are not covered include but are not limited to:
- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or preventive treatment consisting of routine, longterm or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status; and
- vitamin therapy.

Transplant Services
Charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.
- Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement.
- Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel, liver or multi-visceral.
- All Transplant services, other than cornea, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® Facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than CIGNA LIFESOURCE Transplant Network® facilities are payable at the In-Network level. Transplant services received at any other facilities, including Non-

Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services are covered at the Out-of-Network level.

- Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation (refer to Transplant Travel Services), hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation and lodging are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); and lodging while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age. The following are specifically excluded travel expenses:

- Any expense that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available when the covered person is a donor.

Breast Reconstruction and Breast Prostheses

Charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery
Charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Use Disorder.

Inpatient Mental Health Services
Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services
Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Partial Hospitalization or Intensive Outpatient Therapy Program.

Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.
Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24- hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program in accordance with the laws of the appropriate, legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Use Disorder Rehabilitation Services
Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Residential Treatment services.

Substance Use Disorder Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Use Disorder conditions.

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorder Rehabilitation Services
Services provided for the diagnosis and treatment of Substance Use Disorder or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including

outpatient rehabilitation in an individual, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program.

Substance Use Disorder Partial Hospitalization Services are rendered no less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.
A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Use Disorder Detoxification Services
Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions
The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.

  occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

DIABETES TREATMENT
Benefits are available for treatment, medical equipment, supplies and Outpatient self-management training and education, including nutritional counseling, for the treatment of diabetes. In order to be covered, such services must be:

- Prescribed and certified by a Physician as Medically Necessary; and
- Provided by a Network Physician, Registered Nurse, Dietitian, or Pharmacist who has completed a diabetes patient management program recognized by the American Council on Pharmaceutical Education and the Tennessee Board of Pharmacy.

Services and supplies included under this provision shall include:

- Blood glucose monitors, including monitors for the legally blind;
- Test strips for blood glucose monitors;
- Visual reading and urine test strips;
- Injection aids (including diabetic pens);
- Syringes and lancets;
- Insulin pumps, infusion devices, and Medically Necessary accessories;
- Podiatric appliances for prevention of complications associated with diabetes; and
- Glucagon Emergency kits.

(Benefits for insulin and oral hypoglycemic agents will also be available).

Exclusions
The following are specifically excluded from Mental Health and Substance Abuse Services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.

- I.Q. testing.
- Custodial care and/or Custodial Services, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits The Schedule
For You and Your Dependents
This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a Deductible, Copayment or Coinsurance requirement for Covered Expenses for Prescription Drug Products. As applicable, your Deductible or Coinsurance payment will be based on the Plan's Prescription Drug Charge when the Pharmacy is a Network Pharmacy, and the Usual and Customary Charge when the Pharmacy is a non-Network Pharmacy.
Coinsurance The term Coinsurance means the percentage of charges for covered Prescription Drugs and Related Supplies that you or your Dependent are required to pay under this plan.

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Calendar Year Deductible Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Out-of-Pocket Maximum Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Maintenance Drug Products Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Pharmacy or home delivery Pharmacy.		
Certain Preventive Care Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required. Note: Contraceptive devices and oral contraceptives are payable as shown in The Schedule.		
Prescription Drug Products at Retail Pharmacies	The Amount you pay for up to a consecutive 30-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 30-day supply at a Non-Network Pharmacy
Tier 1 Generic Drugs on the Prescription Drug List	10% after plan Deductible	30% after plan Deductible
Tier 2 BrandDrugs designated as preferred on the Prescription Drug List	30% after plan deductible	30% after plan deductible

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	30% after plan Deductible	30% after plan Deductible
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy**
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill.		
Tier 1 Generic Drugs on the Prescription Drug List	10% after plan Deductible	In-Network coverage only
Tier 2 Brand Drugs on the Prescription Drug List	30% after plan Deductible	In-Network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	30% after plan Deductible	In-Network coverage only
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy**
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill and are subject to the same Copayment or Coinsurance that applies to retail Pharmacies.		
Tier 1 Generic Drugs on the Prescription Drug List	10% after plan Deductible	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	30% after plan Deductible	In-network coverage only

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Tier 3 Brand Drugs designated as non- preferred on the Prescription Drug List	30% after plan Deductible	In-Network coverage only

PRESCRIPTION DRUG BENEFITS COVERED EXPENSES

Your plan provides benefits for Prescription Drug Products dispensed by a Pharmacy. Details regarding your plan's Covered Expenses, Limitations and Exclusions are provided below and are shown in The Schedule**.**

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, Cigna will provide coverage for those expenses as shown in The Schedule. Your benefits may vary depending on which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

Coverage under your plan's Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered by Cigna as if filled by a Network Pharmacy. Your payment will be based on the Usual and Customary Charge submitted by the non- Network Pharmacy.

Prescription Drug List Management

The Prescription Drug List (or formulary) offered under your Employer's plan is managed by the Cigna Business Decision Team. Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. The Business Decision Team makes the final assignment of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and decides whether utilization management requirements or other coverage conditions should apply to a Prescription Drug Product by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. When considering a Prescription Drug Product for tier placement on the Prescription Drug List or other coverage conditions, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the

acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). Please access the internet through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

LIMITATIONS

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the diagnosis and the Prescription Drug Product. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the Prescription Drug Product should be covered.

Step Therapy
Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Supply Limits
Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Specialty Prescription Drug Products
Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products.

Designated Pharmacies
If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you may not receive coverage for the Prescription Drug Product or be subject to the non-Network Pharmacy Benefit, if any, for that Prescription Drug Product. Refer to The Schedule for further information.

New Prescription Drug Products
The Business Decision Team may or may not place a New Prescription Drug Product on a Prescription Drug List tier upon its market entry. The Business Decision Team will use reasonable efforts to make a tier placement decision for a New Prescription Drug Product within six months of its market availability. The Business Decision Team's tier placement decision shall be based on consideration of, without limitation, the P&T Committee's clinical review of the New Prescription Drug Product and economic factors. If a New Prescription Drug Product not listed on the Prescription Drug List is approved by Cigna or its Review Organization as Medically Necessary in the interim, the New Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

PAYMENTS

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

When a treatment regimen contains more than one type of Prescription Drug Products that are packaged together for your or your Dependent's convenience, any applicable Copayment or Coinsurance may apply to each Prescription Drug Product.

Any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded and Cigna or its Review Organization approves as Medically Necessary shall be covered at the applicable coverage tier as set forth in The Schedule.

The amount you or your Dependent pays for any excluded Prescription Drug Product or other product or service will not be included in calculating any applicable plan Out-of-Pocket Maximum. You are responsible for paying 100% of the cost (the amount the Pharmacy charges you) for any excluded Prescription Drug Product or other product, and any negotiated Prescription Drug Charge will not be available to you.

EXCLUSIONS

Coverage exclusions listed under the "Exclusions, Expenses Not Covered and General Limitations" section also apply to benefits for Prescription Drug Products. In addition, the exclusions listed below apply to benefits for Prescription Drug Products. When an exclusion or limitation applies to only certain Prescription Drug Products, you can access the internet through the website shown on your ID card or call member services at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

- Coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.
- More than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products dispensed outside the jurisdiction of the United States, except as required for emergency or Urgent Care treatment.

  Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).
- Any product dispensed for the purpose of appetite suppression (anorectics) or

weight loss.

- Prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- Medications used for cosmetic purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth, or medications used to control perspiration and fade cream products.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products used for the treatment of infertility.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.
- Any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).
- Medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- Certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the- counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.

  certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- Medications that are experimental investigational or unproven as described under the "General Exclusion and Limitations" section of your plan's certificate.

REIMBURSEMENT/FILING A CLAIM

Retail Pharmacy

When you or your Dependents purchase your Prescription Drug Products through a retail Network Pharmacy, you pay any applicable Copayment, Coinsurance or Deductible shown in The Schedule at the time of purchase. You do not need to file a claim form unless you purchase a Prescription Drug Product at a non-Network Pharmacy.

Home Delivery Pharmacy
To purchase Prescription Drug Products from a home delivery Network Pharmacy, see your home delivery drug introductory kit for details, or contact member services for assistance.

ADDITIONAL BENEFITS

Tools and Resources at Your Fingertips
To help you understand your benefits, we've created a suite of information and tools that you can access confidentially through our member website, **mycigna.com**.

You have a right to know the cost of services you receive. You have the power to make a difference in the type and quality of those services, You have unique health care needs. And that's why you have mycigna.com – to find value in your health plan. mycigna.com includes helpful resources specifically for members who have Cigna Choice Fund.

- Online access to your current HRA Fund balance, past transactions and claim status, as well as your Explanation of Benefits.
- Your own savings account calculator, with account balance tracking and transaction worksheets to estimate your out-of-pocket expenses.
- Medical cost and drug cost information, including average costs for your state.
- Explanations of other Cigna products and services – what they are and how you can use them.
- Frequently asked questions – about health care in general and Cigna specifically.

A number of convenient, helpful tools that let you:

- Compare costs - Use tools to compare costs and help you decide where to get care. You can get average price ranges for certain ambulatory surgical procedures and radiology services, You can also find estimated costs in your region for common medical services and conditions.
- Find out more about your local hospitals - Learn how hospitals rank by number of procedures performed, patients' average length of stay, and cost. Go to our online provider directory for estimated average cost ranges for certain procedures, including total charges and your out-of-pocket expense, based on a Cigna benefit plan, You can also find hospitals that earn the "Centers of Excellence" designation based on effectiveness in treating selected procedures/conditions and cost.
- Get the facts about your medication, cost, treatment options and side effects - Use the pharmacy tools to: check your prescription drug costs, listed by specific pharmacy and location (including Cigna Tel-Drug); and review your claims history for the past 16 months. Click "WebMD Drug Comparison Tool" under Related Health Resources to look at condition-specific drug treatments and compare characteristics of more than 200 common medications. Evaluate up to 10 medications at once to better understand side effects, drug interactions and alternatives.

- Take control of your health - Take the health risk assessment, an online questionnaire that can help you identify and monitor your health status. You also can find out how your family history may affect you, learn about preventive care and check your progress toward healthy goals. And if your results show that you may benefit from other services, you can learn about related Cigna programs on the same site.
- Explore topics on medicine, health and wellness - Get information on more than 5,000 health conditions, health and wellness, first aid and medical exams through Healthwise®, an interactive library. Research articles on clinical findings through Condition Centers®.
- Keep track of your personal health information - Health Record is your central, secure location for your medical conditions, medications, allergies, surgeries, immunizations, and emergency contacts. You can add your health risk assessment results to Health Record, so you can easily print and share the information with your doctor. Your lab results from certain facilities can be automatically entered into your Personal Health Record.
- Chart progress of important health indicators - Input key data such as blood pressure, blood sugar, cholesterol (Total/LDL/HDL), height and weight, and exercise regimen. Health Tracker makes it easy to chart the results and share them with your doctor.
- Call the toll-free number on your Cigna ID card to reach the Cigna 24-Hour Health Information Line[SM]. You can speak to a trained nurse for guidance on appropriate care or directions to the nearest facility. You also can listen to audio tapes on a variety of health topics. It's easy, reassuring, convenient and confidential.

Cigna Health Advisor[SM]
Your plan includes access to Cigna Health Advisor. Call a Cigna Health Advisor for personalized health and wellness coaching and resources to help you achieve your health-related goals and make the most of your health care benefits. Our team of health and wellness professionals includes registered nurses, health educators and nutritionists, all supported by doctors and pharmacists. Cigna Health Advisors give you a personalized contact for: easy-to-understand health and wellness information based on your specific benefits, needs and preferences; and help evaluating treatment options and navigating the complex health care system. To reach your Cigna Health Advisor, call the toll-free number on your Cigna ID card, Monday-Friday, 9 a.m.-9 p.m. and Saturday, 9-12 p.m. See your benefits administrator for more details.

Getting the Most from Your HRA
As a consumer, you make decisions every day – from buying the family car to choosing the breakfast cereal. Make yourself a more educated health care consumer and you'll find that you, too, can make a difference in the health care services you receive and what you ultimately pay.

Fast Facts
If you choose to see a Cigna participating provider, the cost is based on discounted rates, so your costs will be lower. If you visit a provider not in the network, you may still use Cigna Choice Fund to pay for the cost of those services, but you will pay a higher rate, and you may have to file claims.

If you need hospital care, there are several tools to help you make informed decisions about quality and cost. With the Select Quality Care™ hospital comparison tool on mycigna.com, you can learn how hospitals rank by number of procedures performed, patients' average length of stay, and cost.

Visit our provider directory for Cigna "Centers of Excellence," providing hospital scores for specific procedures/conditions, such as cardiac care, hip and knee replacement, and bariatric surgery. Scores are based on cost and effectiveness in treating the procedure/condition, based on publicly available data. Cigna's website www.cigna.com also includes a Provider Excellence Recognition Directory. This directory includes information on:

- Participating physicians who have achieved recognition from the National Committee for Quality Assurance (NCQA) for diabetes and/or heart and stroke care.
- Hospitals that fully meet The Leapfrog Group patient safety standards.

Wherever you go in the U.S., you take the Cigna 24-Hour Health Information Line℠ with you.
Whether it's late at night, and your child has a fever, or you're traveling and you're not sure where to get care, or you don't feel well and you're unsure about the symptoms, you can call the Cigna 24-Hour Health Information Line whenever you have a question. Call the toll-free number on your Cigna ID card and you will speak to a nurse who will help direct you to the appropriate care.

A little knowledge goes a long way.
Getting the facts about your care, such as treatment options and health risks is important to your health and well-being — and your pocketbook. For instance:

Getting appropriate preventive care is key to staying healthy. Your Cigna participating doctor can provide a wide variety of tests and exams that are covered by your Cigna plan. Visit myCIGNA.com to learn more about proper preventive care and what's covered under your plan. You can also find ways to stay healthy by calling the Cigna 24-Hour Health Information Line, which includes audio tapes on preventive health, exercise and fitness, nutrition and weight control, and more.

When it comes to medications, talk to your doctor about whether generic drugs are right for you. The brand name drugs you are prescribed may have generic alternatives that could lower your costs. If a generic version of your brand name drug is not available, other generic drugs with the same treatment effect may meet your needs.

The health care cost estimator tool on myCIGNA.com can help you use the plan effectively. When planning and budgeting, consider:

- Your medical and prescription drug expenses from last year.
- Any expected changes in your medical spending in the coming year.
- Your anticipated benefit expenses and out-of-pocket costs for the coming year.

- The amount in your CIGNA Choice Fund compared with your expected out-of-pocket costs. Keep in mind the deductible and coinsurance you will pay once the HRA Fund is spent.

Additional tools on myCIGNA.com can help you take control of your health, learn more about medical topics and wellness, and keep track of your personal health information. You can print personalized reports to discuss with your doctor.

SECTION II — ELIGIBILITY

COVERAGE FOR YOU

This Plan describes the benefits you may receive under the CIGNA Choice Fund Open Access Plus Medical Plan.

COVERAGE FOR YOUR DEPENDENTS

If this program covers you, you may enroll your Dependents. Your covered Dependents are also called Members. The names of Dependents for whom application for coverage is made must be listed on the application on file in our records**.** Subsequent applications for Dependents must be submitted to Metro Human Resources in writing.

Dependents shall be limited to include only the following:

- Legally recognized spouse in accordance with the laws of the State of Tennessee, while not divorced or legally separated from the Subscriber;
- Domestic partner and his or her children as outlined in the Domestic Partnership Benefits Policy approved by the Board and where a Declaration of Domestic Partnership has been completed and acknowledged by Metro Human Resources;
- Natural and adopted children of the Subscriber who may or may not reside in the home of the Subscriber the majority of the time on an annual basis;
- "Foster child", which means a child placed with an eligible Subscriber by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- A child of Subscriber or Subscriber's spouse/domestic partner for whom a Qualified Medical Child Support Order has been issued;
- Step-children of the Subscriber; and
- Children, other than those listed above, who are in the Subscriber's legal custody by court order.

Dependent children, as defined above, will be covered from birth until the last day of the month of their twenty-sixth (26th) birthday, married or unmarried.

If on the child's twenty-sixth (26th) birthday, he is Incapacitated, which is defined as incapable of self-sustaining employment by reason of mental retardation or physical handicap, the child shall continue to be deemed a Dependent after said birthday, during the continuation of said incapacity and while he is otherwise included as a Dependent under the above definition, subject to the other terms and conditions of this Plan and to the right of the Administrator to require proof of incapacity when claim is first made for benefits after said birthday, and proof once each year thereafter of the continuation of said incapacity.

Dependents that will **not** be eligible for coverage under this Plan shall include the following:

- Dependents that are not defined in the definitions in this Section;
- Foster children that are not described in the section above headed "Dependents shall be limited to include only the following:";
- Ex-spouses/domestic partners;
- Parents of the Subscriber or spouse/domestic partner; and
- Incapacitated children who the Administrator determines are no longer incapacitated.

A Dependent can be covered only once under this Plan.

TYPES OF COVERAGE AVAILABLE FOR EMPLOYEES

- Individual – Covers the Employee only
- Family – Covers the Employee, Spouse/Domestic Partner and any other Eligible Dependent
- Employee + Child(ren) – Covers the Employee and one or more eligible Dependent Child(ren)
- No Coverage – If you have other non-Medicare medical insurance, you may opt out of Metro's health benefits program in accordance with the Opt Out/Opt In policies adopted by the Board. To opt out, the Employee must provide Metro with proof of other coverage.

TYPES OF COVERAGE AVAILABLE FOR PENSIONERS

If you are a Pensioner, your coverage is affected by whether (1) you or a Dependent is Medicare eligible and (2) if Dependents, including your spouse/domestic partner, are covered. The following levels of coverage are available (for the purpose of this section, "Medicare" means coverage under Medicare Parts A **and** B and eligible domestic partners qualify for the spouse coverage level below):

- Pensioner Only (Individual) – Covers the Pensioner, if the Pensioner does not have Medicare
- Pensioner with Medicare – Covers the Pensioner, if the Pensioner has Medicare
- Pensioner and Dependent(s) (Family) – Covers the Pensioner and at least one Dependent none of whom have Medicare
- Pensioner and Spouse both with Medicare – covers the Pensioner and Pensioner's spouse/domestic partner if both have Medicare or the Pensioner and one Child if both have Medicare
- Pensioner without Medicare, Spouse with Medicare – covers the Pensioner, if the Pensioner does not have Medicare, and Pensioner's spouse/domestic partner, who has Medicare
- Pensioner with Medicare, Spouse without Medicare – covers the Pensioner, who has

Medicare, and Pensioner's spouse/domestic partner without Medicare

- Pensioner, Spouse and Child(ren) all with Medicare – covers the Pensioner, Pensioner's spouse/domestic partner and child (ren), when all three have Medicare
- Pensioner with Medicare and Child (ren) with or without Medicare – covers Pensioner with Medicare and a Dependent child (ren) with or without Medicare;
- Three Family Members Covered with Two of them having Medicare Parts A and B.

ELIGIBLE EMPLOYEES AND PENSIONERS

To be eligible for coverage as an Employee, you must (1) be Regularly Employed; (2) satisfy the Two Quarter Rule; (3) be an official of Metro who is elected by popular vote and is Regularly Employed; (4) be a classified Employee of the Metro Nashville Public Schools or be a classified Employee of a Public Charter school operating within the geographic area served by the Metro Nashville Public School system who is not certified as a teacher and is Regularly Employed (This will generally include "non-certified" Employees who work in the lunch room and in custodian, maintenance, transportation, and clerical positions); (5) be an Employee of the Metropolitan Nashville Hospital Authority; or (6) be an Employee of the Convention Center Authority. Provided however, that otherwise Eligible Employees of Public Charter Schools and the Convention Center Authority shall become Eligible Employees effective as provided by the laws of the State of Tennessee, the Metropolitan Code of Laws or applicable inter-governmental agreements. Solely for purposes of this Plan, the term Employee includes a member of the Metropolitan Council ("Council Member") who is eligible to elect coverage under the plan in accordance with Section 3.24.010(C)(1) of the Metropolitan Code. A Council Member may elect coverage under this Plan by (i) electing to participate and make pre-tax contributions under the Metro Government cafeteria plan, or (ii) making a separate election to make after-tax contributions on a form provided by Human Resources, which election shall be in accordance with, and subject to, rules adopted by the Board.

In the event that each spouse/domestic partner is an Employee, each spouse/domestic partner is a Pensioner, or one spouse/domestic partner is an Employee and the other spouse/domestic partner is a Pensioner, one spouse/domestic partner may opt out of coverage as an Employer or Pensioner and elect to be covered as a Dependent of the Employee or Pensioner. A spouse/domestic partner who is an Employee or Pensioner who elects to be covered as a Dependent as described in the preceding sentence may subsequently elect during any Annual Enrollment, or at such other times that election changes are permitted under the Plan, to again be covered as an Employee or Pensioner. An Employee who is covered as the spouse/domestic partner of another Employee who wishes to change the coverage status to that of an Employee during an Annual Enrollment may make such change in accordance with the rules for election changes generally applicable during Annual Enrollment. An Employee who is covered as the spouse/domestic partner of another Employee who experiences a Change in Family Status who wishes to change the coverage status to that of an Employee must (1) contact Metro Human Resources, and (2) apply for any needed change within sixty (60) calendar days of the Change in Family Status.

"**Regularly employed**" means working a minimum of 20 hours per week, including: (a) nine (9)

month Employees who are scheduled to work 780 hours or more during a calendar year; (b) ten (10) month Employees who are scheduled to work 860 hours or more during a calendar year; and (c) twelve (12) month Employees who are scheduled to work 1040 hours or more during a calendar year.

The "**Two Quarter Rule**" states that an Employee who is not Regularly Employed, but averages 20 hours or more per week in each of two consecutive quarters, becomes eligible for coverage during the following quarter. If an Employee does not average 20 or more hours per week in each of two consecutive quarters, the Employee becomes ineligible for coverage in the following quarter.

To be eligible for coverage as a Pensioner, you must satisfy the guidelines to continue coverage as a Pensioner under the Continuation of Coverage provisions in Section IX.

In addition, if you are a Regular Pensioner, you may elect to continue medical coverage at the time you go on pension. If you do not elect to be covered at the time you go on pension, you are ineligible to enroll at a later date. However, if you have made an election to opt out of the medical care benefits by providing proof of other non-Medicare coverage in accordance with, and subject to, the Opt Out/Opt In policies adopted by the Board effective January 1, 2013, you may opt back into coverage in accordance with the Opt Out/Opt In policies approved by the Board. If you elect not to continue medical benefits when going on pension, your Dependents, including your spouse/domestic partner, will not be eligible for coverage under the Plan in the event of your death**.** If you opted out of coverage and provided proof of other non-Medicare coverage for yourself and each of your eligible Dependents, your spouse/domestic partner will be eligible at your death to opt back into coverage at the time the survivor's pension benefits are being processed or within 60 days of an eligible change in status. If you elect not to cover your spouse/domestic partner at the time of your retirement, your spouse/domestic partner must sign an acknowledgement form stating they understand they will not be covered and that the Pensioner may not subsequently elect to provide coverage under the Plan for such spouse/domestic partner, except (i) if the spouse/domestic partner experiences a Special Enrollment Event (as described on page 66) or (ii) an eligible change in status. A surviving spouse/domestic partner and/or surviving eligible Dependent children of Pensioners, who are entitled to a pension payment by Metro, shall be eligible for the same medical benefits provided for Pensioners as long as they are entitled to a pension payment and were covered by the medical Plan, by the Pensioner, prior to the Pensioner's death or had opted out of coverage in accordance with the Opt Out/Opt In policies adopted by the Board under circumstances that preserved the option of subsequently electing coverage as described in this paragraph.

If you are a Disability Pensioner, you must elect to continue medical coverage for yourself at the time you go on a disability pension unless you have other non-Medicare coverage and elect to opt-out of coverage. If you elect to opt-out of coverage, you may re-enroll at Annual Enrollment, at the time of conversion to a service pension, or if you have a Special Enrollment Event (as defined in the Enrolling in Coverage for Employees and Their Dependents section). If you elect not to cover your spouse/domestic partner at the time of your disability, your spouse/domestic partner must sign an acknowledgement form stating they understand they will not be covered and that the Disability Pensioner may not subsequently elect to provide coverage

under the Plan for such spouse/domestic partner, except (i) if the spouse/domestic partner experiences a Special Enrollment Event (as described on page 66), (ii) an eligible change in status, or (iii) at the time the Disability Pensioner converts to a service pension. A surviving spouse/domestic partner and/or surviving eligible Dependent children of Pensioners, who are entitled to a pension payment by Metro, shall be eligible for the same medical benefits provided for Pensioners as long as they are entitled to a pension payment and were covered in the medical Plan, by the Pensioner, prior to the Pensioner's death, or if the Pensioner had opted out of coverage in accordance with the preceding paragraph, the surviving spouse/domestic partner and/or surviving eligible dependent children of Pensioners may opt back in, in accordance with the Opt Out/Opt In policies adopted by the Board.

A Pensioner's insurance coverage may be terminated for failure to make premium payments in accordance with the Direct Payment of Insurance Premium Policy approved by the Board.

INELIGIBLE SUBSCRIBERS (EMPLOYEES AND PENSIONERS)

Subscribers who are **not** eligible for benefits shall include:

- Certified or licensed Employees whose employment is with the Metropolitan Board of Public Education;
- Employees of the Metropolitan Transit Authority or Employees working for the Metropolitan Transit Authority under contract;
- Employees of the Electric Power Board of The Metropolitan Government of Nashville and Davidson County;
- Employees of The Metropolitan Development and Housing Agency; or
- Employees who are not regularly employed as defined in this Section.
- Employees (i) hired on or after January 1, 2013 or (ii) rehired on or after January 1, 2013 who had not earned a vested right to a pension in accordance with the Metropolitan Code of Laws prior to the date of rehire, are only eligible for medical care benefits as a Regular Pensioner if:

  The Employee is eligible to begin receiving an early or normal service pension at the time of their termination of employment – even if they decide to defer their pension to their unreduced retirement date as outlined in the Metropolitan Code.

  Employees described in items (i) or (ii) in the immediately preceding bulleted paragraph are not eligible for medical care benefits as a Regular Pensioner unless they are eligible to retire immediately with either an early or normal pension as outlined in the Metropolitan Code even if they elect to defer their pension until their unreduced retirement date.

Those Employees covered by one of the plans, prior to August 1, 1990, that do not meet the eligibility criteria on August 1, 1990, shall have their coverage "grand-fathered", even if other Employees in the same classification are not covered.

Each person who is regularly employed, as defined in this Section, except Metro Council members, is mandated by Section 13.07 of the Metropolitan Charter and Section 3.08.010 of the

Metropolitan Code to be a member of the "System".

"System," as defined in Section 3.08.010 of the Metropolitan Code, shall mean the metropolitan employee benefit system, comprising of the following six (6) Plans: Plan for life insurance benefits, Plan for medical care benefits, Plan for disability benefits, Plan for pension benefits for credited employee service, Plan for pension benefits for credited fire and police service, and Plan for hazardous duty death benefit.

DATE OF ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE FOR EMPLOYEES

All persons who meet the definition of an Employee shall become eligible for coverage, and if elected, their coverage will become effective under the Plan on the appropriate date below:

- The first of the month following thirty (30) days after the Employee becomes eligible for benefits;
- With respect to an elected official, the date the elected official takes office; or
- With respect to a Metro Council member, the date the Metro Council member, after being elected and taking office, notifies Human Resources he or she wishes to join the Plan.

Provided the Employee (including an elected official) is "Actively at Work" on the date coverage is to take effect, otherwise on the first date thereafter on which the Employee or elected official is Actively at Work.

The Effective Date of coverage may be a Saturday or Sunday; however, if the Employee (including an elected official) is not scheduled to work on his Effective Date of coverage, to satisfy this requirement, he must have been "Actively at Work" the last scheduled work day before the Effective Date of coverage.

"Actively at Work" means the performance of all of an Employee's regular duties for Metro on a regularly scheduled workday at the location where such duties are normally performed. An Employee will be considered to be Actively at Work on a non-scheduled work day (which would include a regularly scheduled vacation day) only if he or she was Actively at Work on the last regularly scheduled workday. An Employee who is not at work due to a health-related factor shall be treated as Actively at Work for purposes of determining eligibility. If it is determined, the Employee was not Actively at Work on the date coverage should have begun, the Effective Date of Coverage will be delayed until the date the Employee meets the definition of Actively at Work.

Effective Date after Leave of Absence

An Employee that is on a leave of absence and did not obtain COBRA coverage while on the leave of absence, whether such leave be approved or unapproved, will be automatically re-enrolled with the same health care Plan when he returns to work, with the same level of coverage that the Employee had before the leave of absence. Under these circumstances, coverage will be effective the first of the month following thirty (30) days from the date he or she returns from the

leave of absence.

However, if the Employee is on a leave of absence, whether such leave be approved or unapproved, for less than thirty (30) calendar days, his coverage will be automatically reinstated with no break in coverage and the Employee must therefore pay any contributions that are owed to continue coverage during the leave of absence.

Disciplinary Action Reinstatement
Any Employee whose employment is terminated due to disciplinary charges and subsequently his employment is reinstated by a court or other authority with jurisdiction over the employment status of the Employee, will, except as provided under Reinstatement Pursuant to Court Order below, have his insurance coverage reinstated on either:

1. The date the Employee returns to work; or
2. The first of the month following thirty (30) days after the Employee returns to work, whichever the Employee elects.

If the Employee elects option (1) above, the Employee must pay any contributions for past months so that coverage will be continuous.

If the Employee is enrolled in Family or Employee + Child(ren) coverage, the Dependents will have the same Effective Date as the Employee. Coverage for the Covered Person will not take effect on the date outlined above if the Covered Person is hospitalized on the date coverage is reinstated. The Effective Date will then be delayed to the date as outlined in this section for an Employee and to the date outlined below for Dependents.

Reinstatement Pursuant to Court Order

(a) If an Employee whose employment is terminated for disciplinary reasons shall be reinstated to employment by an order of a court or other authority with jurisdiction over the employment status of an Employee, such Employee shall have the insurance coverage reinstated. If the effective date of such reinstatement of coverage shall be prior to the date the Employee returns to work, such Employee must pay any contributions required for such coverage which otherwise would have been due between the date his or her coverage ceased because of such disciplinary termination and the date such employee returns to work. The effective date of such coverage reinstatement shall be the applicable date described below:

(i) The date specified in such order, or

(ii) If no date is specified in such order, the date such employee returns to work, or

(iii) If the reinstatement is determined under subparagraph (a) above, and such date is prior to the date such Employee returns to work, such Employee

may elect to have his or her coverage reinstated effective as of the date he or she returns to work. Such election shall be made in accordance with Section 3.2 of the Metropolitan Government of Nashville & Davidson County Amended and Restated Cafeteria plan with Flexible Spending Arrangement (the "Cafeteria Plan").

(b) In the event an Employee, and/or his or her Dependents, whose coverage is retroactively reinstated and who did not make the election described in subsection (a)(iii) immediately above shall have claims which claims would have been subject to pre-authorization requirements which are incurred at any time between the effective date of the retroactive reinstatement of coverage and the date the Employee returns to work, the following special rules shall apply:

(i) Such claim shall not be denied or reimbursement therefore shall not be reduced simply because the Employee or Dependent did not comply with such pre-authorization requirements at the time the claim was incurred.

(ii) The pre-authorization process shall be applied to such claim at the time it is submitted based on the standards used by the Administrator to approve or deny such pre-authorization which were in effect at the time the claim was incurred.

(iii) The Administrator and the Plan Administrator may take into account such facts not related to the Employee's medical condition that exist at the time a decision or appeal of a decision on pre-authorization is made; provided however, that the Administrator or Plan Administrator shall not consider any facts respecting the Employee's or Dependent's medical condition which are or could be material to the pre-authorization determination that were first discovered at or after the time the Employee or Dependent first received the treatment for which the pre-authorization was required.

Effective Date after Termination

If an Employee terminates employment and returns to work for Metro within thirty (30) days of the date of termination, coverage will automatically be reinstated retroactively to the date coverage would have terminated. The Employee will be responsible for paying any contributions that are due so that there will not be a break in coverage. The appropriate contribution will be deducted from the Employee's paycheck.

If the Employee's date to return to work at Metro is more than thirty (30) days from the date of termination, the Employee will be treated as a newly eligible Employee.

DATE OF ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE FOR PENSIONERS

All persons who meet the definition of a Pensioner shall become eligible for coverage in the Plan and have coverage effective on the date the pension benefit becomes effective. Regular Pensioners who do not elect to continue coverage at the first time they become eligible, may not elect coverage at a later time, unless the Pensioner made an election to opt out of the medical care benefits by providing proof of other non-Medicare coverage in accordance with, and subject to, the Opt Out/Opt In policies adopted by the Board effective January 1, 2013 . Pensioners have the option of electing Family coverage or adding Dependents at the time their pension becomes effective. Pensioners electing Individual coverage at the time of pension or electing Family Coverage but not declaring certain Dependents will not be permitted to change to Family Coverage or to add those Dependents during an Annual Enrollment period. The only permitted changes are those that qualify as a "Special Enrollment Event" as described in the Enrolling in Coverage for Pensioners and Dependents below.

DECLARING DEPENDENTS

Subscribers must list, on the appropriate enrollment application, all Dependents covered under the Plan. If the Dependent is not listed on the appropriate enrollment application, benefits will not be provided under the Plan. Human Resources have the right to require documentation at any time to prove eligibility of Dependents enrolled in the Plan.

DATE OF ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE FOR EMPLOYEE'S DEPENDENTS

Your Dependents become eligible for benefits on the latest to occur of the date that you become eligible under this Plan or the date that the Dependent meets the definition of Dependent under the Coverage for Dependents section above. Coverage for Dependents becomes effective on the same date as your Effective Date of coverage if you have elected coverage for your Dependents.

Effective Date when Adding a Dependent

If you are enrolled in the Before–Tax Premium Savings Plan, restrictions are placed on adding Dependents to this Plan. If you want to add a Dependent and you are enrolled in the Before–Tax Premium Savings Plan, the Effective Date of coverage for the Dependent(s) will be the date specified in this Section:

- When an Employee has Individual coverage and the Employee elects to add a Dependent(s) within sixty (60) calendar days of a Change in Family Status, the Effective Date of coverage for the Dependent(s) and the change to Family or Employee + Child(ren) coverage will be the date of the Change in Family Status. The Employee must complete the appropriate enrollment form through Human Resources within sixty (60) calendar days of the Change in Family Status. The Employee will be required to pay any additional contribution.
- When an Employee has Individual coverage and the Employee elects to add a Dependent(s) after sixty (60) calendar days of a Change in Family Status, the Effective Date of coverage for the Dependent(s) and the change to Family or Employee + Child(ren) coverage will be effective at the next Annual Enrollment period by completing the appropriate Annual

Enrollment forms through Human Resources.

- When an Employee has Family or Employee + Child(ren) coverage and the Employee elects to add a Dependent(s) within sixty (60) calendar days of a Change in Family Status, the Effective Date of coverage for the Dependent(s) will be the latest of:
- The date of the Change in Family Status;
- The date the Employee acquired the Dependent; or,
- The date the Employee enrolled in Family or Employee + Child(ren) coverage
- The Employee must complete the appropriate enrollment form through Human Resources to add the Dependent(s).
- When an Employee has Family coverage, Dependents may be added even if there is no Change in Family Status or when an Employee has Employee + Child(ren) coverage, Dependent Children may be added even if there is no Change in Family Status. The Effective Date of the added Dependents coverage will be the latest of:
- The date of the Change in Family Status;
- The date the Employee enrolled in Family or Employee + Child(ren) coverage; or,
- The first of the current month if the Dependent is being added after sixty (60) calendar days

DATE OF ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE FOR PENSIONER'S DEPENDENTS

Your Dependents become eligible for benefits on the latest to occur of the date that you become eligible under this Plan or the date that the Dependent meets the definition of Dependent under the Coverage for Dependents section above. Coverage for Dependents becomes effective on the same date as your Effective Date of coverage if you have elected coverage for your Dependents.

Effective Date when Adding a Dependent

If you want to add a Dependent, you must add the Dependent within sixty (60) calendar days of a Special Enrollment Event (as defined in Enrolling in Coverage for Pensioners and their Dependents Section) or the Dependent may not be added at a later time. When a Pensioner has Individual coverage and the Pensioner elects to add a Dependent(s) within sixty (60) calendar days of a Special Enrollment Event, the Effective Date of coverage for the Dependent(s) and the change to Family coverage will be the date of the Special Enrollment Event. The Pensioner must complete the appropriate enrollment form through Human Resources within sixty (60) calendar days of the Special Enrollment Event. The Pensioner will be required to pay any additional contribution.

ENROLLING IN COVERAGE FOR EMPLOYEES AND THEIR DEPENDENTS

After meeting the eligibility requirements, you may apply for one of the types of coverage shown above. You have thirty (30) days from your date of eligibility, as defined above, to choose coverage for your Dependents or to choose an alternative health care plan such as the CIGNA Choice Fund Plan. To enroll in coverage, you must complete the proper benefit enrollment

forms through Human Resources. If you fail to enroll during the thirty (30) day enrollment period, you will automatically be enrolled by Human Resources with individual coverage under the medical Plan outlined in this document.

If You Did Not Enroll On Time
If you wait more than thirty (30) days from the date you are first eligible to apply or add a Dependent, the Dependent will be considered a Late Enrollee and will not be eligible for benefits until the next Annual Enrollment period or unless you have a special enrollment right under the Health Information Portability and Accountability Act of 1986 (HIPAA).

HIPAA gives you certain Special Enrollment rights. If you decline coverage for yourself or Dependents, you and/or your Dependents may enroll under certain circumstances, provided you request enrollment by completing and submitting enrollment materials otherwise required for coverage to become effective within sixty (60) calendar days of certain Special Enrollment Events. These events, and the rights they confer, follow.

Employee Loses Coverage: If you were eligible but did not enroll in the Plan, and explained in writing as required under the Plan that you had other coverage, even if it were COBRA continuation coverage, and that other coverage has now expired, you are entitled to special enrollment. However, to be entitled to special enrollment, the other coverage must have been lost because of loss of eligibility, loss of an employer contribution or exhaustion of COBRA continuation coverage.
If the above conditions are satisfied, you and/or your Dependents may enroll effective the first day after your other coverage terminates. Your request for enrollment must be received within sixty (60) calendar days of the loss of coverage.

Dependent Loses Coverage: If your Dependent was eligible but not enrolled in the Plan, and the Dependent had other coverage, even if it were COBRA continuation coverage, which has expired because of loss of eligibility, loss of an employer contribution or exhaustion of COBRA continuation coverage, your Dependent is entitled to special enrollment.
If the above conditions are satisfied, your Dependent may enroll effective the first day after your other coverage terminates. Your request to enroll your Dependent must be received within sixty (60) calendar days of the loss of coverage.

Acquisition of Dependent: If you and/or your Dependents were eligible but not enrolled in the Plan, and you gained a Dependent through marriage, birth, adoption or placement for adoption, you and/or your Dependents are entitled to special enrollment.

Enrollment for you and/or the Dependent (including spouse/domestic partner) will be effective on the date of birth, adoption or placement for adoption. In the case of marriage, enrollment will be effective the date of the marriage. Your request to enroll your Dependent must be received within sixty (60) calendar days of the event.

For purposes of special enrollments, loss of eligibility for other coverage includes loss due to legal separation, divorce, death, termination of employment or reduction in work hours. Such loss of eligibility does not apply when loss of coverage is due to failure to pay contributions on a

timely basis, or for cause, such as making fraudulent claims or intentional misrepresentations of material facts in connection with the Plan.

ENROLLING IN COVERAGE FOR PENSIONERS AND THEIR DEPENDENTS

At the time of Service pension eligibility, if you meet the definition of Regular Pensioner, you may enroll yourself and your Dependents. If you meet the definition of Disability Pensioner, you are required to maintain coverage for yourself through the Plan, unless proof of other non-Medicare coverage is provided and an opt-out election is made. As a Disability Pensioner, you may also enroll your Dependents at the time of pension eligibility. You may apply for one of the types of coverage shown above. You have the option of electing Family coverage and adding Dependents at the time that your pension becomes effective.

If You Did Not Enroll at Pension Eligibility

If you did not enroll at the time you were initially eligible for a service pension, you and your Dependents may not enroll in the plan at a later time, unless you and your eligible Dependents have made an election to opt out of the medical care benefits by providing proof of other non-Medicare coverage in accordance with, and subject to, the Opt Out/Opt In policies adopted by the Board effective January 1, 2013.

If you are a Disability Pensioner and you opted out of coverage, you will be considered a Late Enrollee and will not be eligible to enroll in benefits until the next Annual Enrollment period, unless you have special enrollment rights under the Plan or HIPAA. To exercise these special enrollment rights, you must request enrollment by completing and submitting enrollment materials otherwise required for coverage to become effective within sixty (60) calendar days of certain Special Enrollment Events. Failure to request special enrollment within sixty (60) calendar days of the event means that you will not ever be able to enroll that Dependent. These events, and the rights they confer, follow:

> **Disability Pensioner Loses Coverage:** If you were eligible but did not enroll in the Plan, and explained in writing as required under the Plan that you had other coverage, even if it were COBRA continuation coverage, and that other coverage has now expired, you are entitled to special enrollment. However, to be entitled to special enrollment, the other coverage must have been lost because of loss of eligibility, loss of an employer contribution or exhaustion of COBRA continuation coverage.
> If the above conditions are satisfied, you and/or your Dependents may enroll effective the first day after your other coverage terminates. Your request for enrollment must be received within sixty (60) calendar days of the loss of coverage.
>
> **Special Enrollment of Dependents**: Other than an enrollment of a Dependent that is covered by the loss of your coverage above, your Dependents special enrollment rights are governed by the following subsection entitled "If you Did Not Enroll your Dependents on Time."

For purposes of special enrollments, loss of eligibility for other coverage includes loss due to legal separation, divorce, death, and termination of employment or reduction in work hours.

Such loss of eligibility does not apply when loss of coverage is due to failure to pay contributions on a timely basis, or for cause, such as making fraudulent claims or intentional misrepresentations of material facts in connection with the Plan.

If You Did Not Enroll Your Dependents On Time

If you did not enroll a Dependent who was eligible at the time of pension eligibility, you may not enroll that Dependent unless that Dependent has a special enrollment right under HIPAA. To exercise these special enrollment rights, you must request enrollment by completing and submitting enrollment materials otherwise required for coverage to become effective within sixty (60) calendar days of certain Special Enrollment Events. Failure to request special enrollment within sixty (60) calendar days of the event means that you will not ever be able to enroll that Dependent. These events, and the rights they confer, follow.

Special Enrollment of a Spouse/Domestic Partner: If you are enrolled in the Plan, your spouse/domestic partner is entitled to special enrollment if (a) you marry (and the marriage is legally recognized by the State of Tennessee (b) you acquire another Dependent through birth, adoption, or placement for adoption; or (c) your spouse/domestic partner had other coverage that has now expired. However, for your spouse/domestic partner to be entitled to special enrollment because of loss of the spouse's/domestic partner's other coverage, the other coverage must have been lost as a result of: 1) loss of eligibility 2) loss of an employer contribution, 3) exhaustion of COBRA continuation coverage; or 4) exceeding the lifetime maximum benefit under such other coverage.

Special Enrollment of a Dependent Other than a Spouse/Domestic Partner: If you are enrolled in the Plan, and you acquire a Dependent other than a spouse/domestic partner by (a) marriage as legally recognized by the State of Tennessee (such as a step-child), birth, adoption, or placement for adoption or (b) your Dependent other than a spouse/domestic partner had other coverage and that other coverage has now expired, the newly acquired Dependent or Dependents are entitled to special enrollment. However, for your Dependent(s) to be entitled to special enrollment because of loss of the Dependent's other coverage, the other coverage must have been lost as a result of: 1) loss of eligibility 2) loss of an employer contribution, 3) exhaustion of COBRA continuation coverage; or 4) exceeding the lifetime maximum benefit under such other coverage. Your request to enroll your Dependent must be received within sixty (60) calendar days of the event.

What this Means to You:

If you did not enroll your spouse/domestic partner or Dependent children at the time you went on pension, you may only enroll your Dependents within 60 days of a special enrollment right. A special enrollment is considered to be:

a) the birth of your Dependent child at which time you may also add your spouse/domestic partner;

b) the date of your Dependent child's adoption or placement for adoption (the period of time immediately preceding the final adoption) at which time you may also add your spouse/domestic partner;

c) the date of your marriage as legally recognized by the State of Tennessee at which time you may also add any Dependent step-children; or

d) when your spouse/domestic partner or Dependent child loses coverage due to:

   1) loss of eligibility

   2) loss of an employer contribution

   3) or when their COBRA coverage has expired.

CHANGING COVERAGE FOR EMPLOYEES – CHANGES IN FAMILY STATUS

If your marital status changes (marriage or divorce), your relationship with your domestic partner ends, your spouse/domestic partner experiences a loss of coverage, or if there is a change in the number of your children (e.g., birth, adoption), you may want to change your coverage to one of the other options available. You should contact Metro Human Resources to discuss how these changes impact your benefits. (See "Types of Coverage Available for Employees" section on page 57.)

When you need to make a change, you should (1) contact Metro Human Resources, and (2) apply for any needed change within sixty (60) calendar days of the Change in Family Status, of the date the new Dependent is acquired, etc. If your domestic partnership has ended, you must notify Metro Human Resources and complete a Termination of Domestic Partnership form within thirty (30) days of the partnership termination.

A newborn child of the Employee or Employee's spouse is a Covered Dependent from the moment of birth. The Employee must enroll that child within sixty (60) calendar days of the date of birth. If the Employee fails to do so, the Plan will not provide Coverage for that child after sixty (60) calendar days from the child's date of birth until the child is added as a Dependent during the next annual enrollment (or unless the Employee has Family or Employee + Child(ren) coverage, where no additional payment is required to cover the child, and the Employee contacts Human Resources and completes appropriate paperwork to add the child).

Coverage for new Dependents added begins on the date the Dependent is acquired if the application is received within sixty (60) calendar days after that date.

CHANGING COVERAGE FOR PENSIONERS – CHANGES IN FAMILY STATUS

The types of changes that you are permitted to make as a Pensioner to your and your Dependents medical coverage depends upon whether you are a Regular Pensioner or a Disability Pensioner.

If you are a Regular Pensioner who has not elected a Survivor Option under the Metro Pension Plan, you may drop coverage for you or your Dependents at any time. Please note that once you drop coverage for you or your Dependents, you will not be able to re-enroll yourself or the Dependents that you drop from coverage to the Plan unless you and your eligible Dependents have made an election to opt out of the medical care benefits by providing proof of other non-Medicare coverage in accordance with, and subject to, the Opt Out/Opt In policies adopted by the Board effective January 1, 2013.. As a Regular Pensioner, you are not eligible to enroll a

Dependent in coverage unless that Dependent has a Special Enrollment Event as described in the "Enrolling in Coverage for Pensioners and their Dependents" section above.

If you are a Regular Pensioner who has elected a Survivor Option under the Metro Pension Plan, you may drop coverage for your Dependents who are not your spouse/domestic partner at any time. You may not, however, drop coverage for your spouse/domestic partner or yourself and your spouse/domestic partner, without the written acknowledgement of your spouse/domestic partner. Please note that once you drop coverage for you or your Dependents, you will not be able to re-enroll yourself or the Dependents that you drop from coverage to the Plan, unless you and your eligible Dependents have made an election to opt out of the medical care benefits by providing proof of other non-Medicare coverage in accordance with, and subject to, the Opt Out/Opt In policies adopted by the Board effective January 1, 2013. As a Regular Pensioner, you are not eligible to enroll a Dependent in coverage unless that Dependent has a Special Enrollment Event as described in the Enrolling in Coverage for Pensioners and their Dependents section above.

If you are a Disability Pensioner, you are not permitted to drop coverage for yourself unless you have other coverage and an opt-out election is made. The opt-out election may be made only at Annual Enrollment or within 60 days of obtaining other coverage. You are permitted to drop coverage for your Dependents at any time. Please note that once you drop coverage for your Dependents, you may not re-enroll those dependents at any time unless you have dropped those Dependents in connection with the dropping of your coverage through an opt-out election or in connection with an eligible change in status. The ability to add other Dependents is governed by the "Special Enrollment Events of the Enrolling in Coverage for Pensioners and their Dependents" section above. In addition, you may elect to cover your Dependents at the time your disability pension converts to a service pension.

SECTION III — COST CONTAINMENT FEATURES: WHAT THEY ARE AND HOW TO USE THEM

PLAN PROVISIONS

When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction With Your Medical Plan

You can access these services by calling the toll-free number shown on the back of your ID card.

CIGNA'S Toll-Free Care Line

CIGNA's toll-free care line allows you to talk to a health care professional during normal business hours, Monday through Friday, simply by calling the toll-free number shown on your ID card.

CIGNA's toll-free care line personnel can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may consult your Physician Guide which lists the Participating Providers in your area or call CIGNA's toll-free number for assistance. If you or your Dependents need medical care while away from home, you may have access to a national network of Participating Providers through CIGNA's Away-From-Home Care feature. Call CIGNA's toll-free care line for the names of Participating Providers in other network areas. Whether you obtain the name of a Participating Provider from your Physician Guide or through the care line, it is recommended that prior to making an appointment you call the provider to confirm that he or she is a current participant in the Open Access Plus Program.

CASE MANAGEMENT

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates,

oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your Dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our Members for the purpose of promoting the general health and well being of our Members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

WHAT YOU CAN DO TO CONTAIN COSTS

In order to take advantage of the cost-saving features of this program, it's important that you follow some basic procedures.

Before you receive health care services, you should be sure that your health care provider is a Network Provider. Although you may have received a directory listing the Network Providers in your area, there may have been changes since printing.

SECTION IV — LIMITATIONS/EXCLUSIONS

EXCLUSIONS, EXPENSES NOT COVERED AND GENERAL LIMITATIONS

The services and supplies described in this Plan are subject to Medical Necessity and Appropriateness, coverage provisions and the following limitations and exclusions. When a service or supply is limited or excluded all expenses related to and in connection with the service and/or supply will also be limited or excluded. Read this section carefully before submitting a claim.

EXCLUSIONS

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;

- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- regardless of clinical indication for acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery
- for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung, and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:
- medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and
- weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male and female voluntary sterilization procedures.
- transsexual surgery.

- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling and/or ancillary services, including but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses. therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs) for members age 18 and older. A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery, or as otherwise provided under the Plan.
- charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the "Schedule of Prescription Drug Benefits" beginning on page 48, or elsewhere in this plan.

- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease, except as otherwise provided under "Genetic Testing" on page 37.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

SECTION V — CLAIMS AND PAYMENT

CLAIMS AND PAYMENT

The prompt filing of any required claim form will result in faster payment of your claim. You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing Cigna Claim Office. Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to Cigna.

Doctor's Bills and Other Medical Expenses

The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS

Be sure to use your Member ID and account number when you file Cigna claim forms, or when you call your Cigna claim office. Your Member ID is the ID shown on your benefit identification card. Your account number is the 7-digit policy number shown on your benefit identification card. Prompt filing of any required claim forms results in faster payment of your claims.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

PAYMENT OF BENEFITS

To Whom Payable

All Medical Benefits are payable to you. However, at the option of Cigna, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical Benefits are not assignable unless agreed to by Cigna. Cigna may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of Cigna, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no

request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, Cigna may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Time of Payment
Benefits will be paid by Cigna when it receives due proof of loss.

Recovery of Overpayment
When an overpayment has been made by Cigna, Cigna will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses
Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

SECTION VI — GRIEVANCE

WHEN YOU HAVE A COMPLAINT OR APPEAL

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted. "Physician Reviewers" are licensed Physicians depending on the care, service or treatment under review. We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call the toll-free number on your Benefit Identification card, Explanation of Benefits, or claim form and explain your concern to one of our Member Services representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write us at the toll-free number on your Benefit Identification card, Explanation of Benefits, or claim form.

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, Cigna will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we received an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician,

will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing. A copy of the first level appeal decision issued to you will also be sent to the appropriate designated staff member for the plan.

Next-Level Grievance Procedure
If you disagree with the decision of the first level Cigna Physician reviewer, you may appeal the decision to the Metro Employee Benefit Board which has full discretionary authority to make eligibility, benefit and/or claim determinations.

Determinations by the Board, CIGNA Health Care and such other reviewers shall be subject to the review standards adopted by the Plan Administrator, as described in Appendix 1.

SECTION VII — RIGHTS OF RECOVERY AND REIMBURSEMENT

RIGHT OF RECOVERY

The Policy does not cover:

- Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Dependent(s).
- Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government insurance, other than Medicaid, or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur health care Expenses as described in (1) and (2) above, Cigna shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the Policy. You or your Dependent(s) or their representative shall execute such documents as may be required to secure Cigna's rights. Cigna shall be reimbursed the lesser of:

- The amount actually paid by Cigna [or the HealthPlan] under the Policy; or
- an amount actually received from the third party;
- at the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

SUBROGATION

In addition to the Right of Recovery above, if another party is legally responsible for causing a Member's illness or injury, that Member shall be deemed to assign, transfer and subrogate all of his or her rights of action against any Responsible Parties to Metro and to Cigna, to the full extent benefit payments were made for Covered Services provided to treat such illness or injury, plus the costs of recovering such amounts from those Responsible Parties, whether or not the Member has been made whole by such Parties. Such actions may be based in tort, contract or other cause of action, to the fullest extent permitted by law.

LIEN

Metro and Cigna shall have a lien against any payment judgment or settlement of any kind that a Member receives from or on behalf of Responsible Parties for the cost of providing services to that Member and any costs of recovering such amounts from Responsible Parties, whether or not the Member is made whole by that recovery. Metro or Cigna may notify other parties of its lien without notice to, or the consent of, that Member.

The recovery and subrogation rights stated in this provision shall be considered to be a first priority claim against the proceeds of any judgment against, settlement with, or payment from Responsible Parties; to be paid before any other claims are paid, whether or not the Member has

recovered the total amount of his or her damages. In the event the Member settles any claim or action against any third party, Metro or Cigna shall be entitled to immediately collect the present value of its claims pursuant to this section as the first priority claim from the settlement fund. Any such proceeds of settlement or judgment shall be held in trust by the Member for the benefit of Metro.

NOTICE AND COOPERATION

Members must promptly notify the Claims Administrator if they are injured or become ill as a result of the act or omission of other parties, to enable the Plan to protect its rights pursuant to this section. Members must cooperate with the Plan and agree to execute any documents that Metro Government or Claims Administrator deems necessary to protect the rights of the Metro Government under this section. The Member is solely responsible for paying all costs of litigation, including any attorney fees and expenses, regarding any proceeds obtained from any judgment against, settlement with, or payment from Responsible Parties. The Plan will not pay the attorney fees for the Member's attorney.

SECTION VIII — TERMINATION, REINSTATEMENT AND CONTINUATION OF COVERAGE

TERMINATION OF COVERAGE

A Subscriber loses eligibility when one of the following occurs:

- The Subscriber no longer meets the definition of an eligible Subscriber as defined, including when an Employee has worked less than an average of twenty (20) hours per week in two (2) consecutive quarters;
- The Employee terminates his or her employment;
- The Subscriber fails to make the required contribution to Metro by either (a) payroll deduction or (b) direct payment for his or her participation under this Plan, unless otherwise stated;
- The Plan is amended to terminate the coverage of a class of Subscribers of which the Subscriber is a Member; or
- The Plan terminates.

When a Subscriber loses eligibility, the Subscriber's Coverage under this Plan will terminate on the earliest of the following dates:

- The end of the month following the last day for which the Employee is paid by Metro when the Employee's employment has terminated or when the Employee has been on a paid leave;
- The end of the month following the date the Subscriber no longer meets the definition of a Subscriber or fails to make the required contribution to Metro;
- The date the Plan is amended to terminate the coverage of a class of Subscribers of which the Subscriber is a Member;
- The date the Plan terminates; or
- The end of the month following the date the Subscriber opts out of coverage for a qualifying event as allowed under the Opt Out/Opt In Policies adopted by the Board.

A Dependent loses eligibility when one of the following occurs:

- The Subscriber's benefits under the Plan end;
- The Dependent no longer meets the definition of an eligible Dependent;
- The period for which the Subscriber last made the required contribution for participation of his or her Dependents under this Plan ends;
- The Dependent commences active duty in the armed forces of any country or state or international organization, or becomes a member of any civilian force auxiliary to any military force;

- The Subscriber's benefits under the plan end due to their opting out of coverage; or
- The Plan terminates.

When a Dependent loses eligibility, the Dependent's Coverage under this Plan will terminate on the earliest of the following dates:

- The end of the month following the date the Dependent no longer meets the definition of a Dependent or the Subscriber fails to make the required contribution to Metro for the Dependent's Coverage;
- The end of the month following the last day for which the Employee is paid by Metro when the Employee's employment has terminated or when the Employee has been on a paid leave;
- The end of the month following the date the Subscriber opts out of coverage for a qualifying event as allowed under the Opt Out/Opt In Policies adopted by the Board;
- The date the Plan is amended to terminate the coverage of a class of Employees through which the Employee is Covered; or
- The date the Plan terminates.

When a Member's Coverage terminates, the Subscriber's contributions may be refunded back to the earlier of:

- The end of the month following the date Metro receives notice of the Member's loss of eligibility;
- The end of the month following the date the Member loses eligibility; or
- This refund will not exceed the Subscriber's contributions made for the ninety (90) day period before the end of the month during which Metro is notified of the loss of eligibility.

REINSTATEMENT OF COVERAGE

If an Employee terminates employment and returns to work for Metro within thirty (30) days of the date of termination, coverage will automatically be reinstated by Human Resources retroactively to the date coverage would have terminated. The Employee will be responsible for paying any contributions that are due so that there will not be a break in coverage. The appropriate contribution will be deducted from the Employee's paycheck.

If the Employee's date to return to work at Metro is more than thirty (30) days from the date of termination, the Employee will be treated as a newly eligible Employee.

TRANSFERRING COVERAGE FROM OTHER METRO PLANS

Human Resources will determine under what terms and conditions an Employee may transfer coverage from another health care plan, for which Metro contributes to the contribution on

behalf of the Metro Employee, to this Plan. In general, Human Resources will reciprocate and therefore follow the same guidelines that the other Metro health care plan will follow when a Metro Employee transfers from this Plan to their health care plan. These guidelines will include the Effective Date of coverage.

CONTINUATION COVERAGE

There are certain circumstances under which a you or a Dependent may continue coverage with the Plan even though you are no longer on the active Metro payroll due to termination of employment, retirement or a leave of absence, or because you or a Dependent no longer meet the eligibility rules. These circumstances are discussed in the following paragraphs.

Continuation Coverage under COBRA

If the ASA remains in effect, but your Coverage under this Plan would otherwise terminate, Metro may offer you the right to continue Coverage. This right is referred to as "COBRA Continuation Coverage" and may occur for a limited time subject to the terms of this Section and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA.)

Eligibility

If you have been Covered by the Plan on the day before a qualifying event, you and your Covered Dependents may be eligible for COBRA Continuation Coverage. The following are qualifying events for such Coverage:

- Subscribers. Loss of Coverage because of:
    - The termination of employment except for gross misconduct; or
    - A reduction in the number of hours worked by the Subscriber.
- Covered Dependents. Loss of Coverage because of:
    - The termination of the Subscriber's Coverage as explained in subsection (a), above;
    - The death of the Subscriber;
    - Divorce or legal separation from the Subscriber;
    - Termination of the domestic partnership;
    - The Subscriber becomes entitled to Medicare; or
    - A Covered Dependent reaches the Limiting Age or becomes eligible to enroll in his/her own employer-sponsored health plan.

Enrolling for COBRA Continuation Coverage

The COBRA administrator, acting on behalf of Metro, shall notify you of your rights to enroll for COBRA Continuation Coverage after:

- The Subscriber's termination of employment, reduction in hours worked, death or entitlement to Medicare coverage; or
- The Subscriber or Covered Dependent notifies Metro, in writing, within sixty (60) days after any other qualifying event set out above.

You have sixty (60) days from the later of the date of the qualifying event or the date that you receive notice of the right to COBRA Continuation Coverage to enroll for such Coverage. Metro or the COBRA administrator will send the forms that should be used to enroll for COBRA Continuation Coverage. If you do not send the Enrollment Form to Metro within that 60-day period, you will lose your right to COBRA Continuation Coverage under this Section. If you are qualified for COBRA Continuation Coverage and receive services that would be Covered Services before enrolling and submitting the Payment for such Coverage, you will be required to pay for those services. The Plan will reimburse you for Covered Services, less required Member payments, after you enroll and submit the Payment for Coverage, and submit a claim for those Covered Services as set forth in the Claim Procedure section of this Medical Plan Document.
Certain employees who have been displaced by import competition or shifts of production to foreign countries may receive a second 60-day election period during the six (6) months following the end of their group health coverage.

Payment
You must submit any Payment required for COBRA Continuation Coverage to the COBRA administrator at the address indicated on your Payment notice. The Payment due for the period between the date you first become eligible and the date you enroll for COBRA Continuation Coverage must be paid to Metro (or to the COBRA administrator, if so directed by Metro) within forty-five (45) days after the date you enroll for COBRA Continuation Coverage. After enrolling for COBRA Continuation Coverage, all Payments are due and payable on a monthly basis as required by Metro. If the Payment is not received by the COBRA administrator on or before the due date, Coverage will be terminated, for cause, effective as of the last day for which Payment was received as explained in the Termination of Coverage Section. The COBRA administrator may use a third party vendor to collect the COBRA Payment.

Coverage Provided
If you enroll for COBRA Continuation Coverage you will continue to be Covered under the Plan and this Medical Plan Document. The COBRA Continuation Coverage is subject to the conditions, limitations and exclusions of this Medical Plan Document and the Plan. The Plan and Metro may agree to change the ASA and/or this Medical Plan Document. Metro may also decide to change COBRA administrators. If this happens after you enroll for COBRA Continuation Coverage, your Coverage will be subject to such changes.

Duration of Eligibility for COBRA Continuation Coverage
COBRA Continuation Coverage is available for a maximum of:

- Eighteen (18) months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or

- Thirty-six (36) months for other qualifying events. If a Covered Dependent is eligible for 18 months of COBRA Continuation Coverage as described above, and there is a second qualifying event (e.g., divorce), you may be eligible for thirty-six (36) months of COBRA Continuation Coverage from the date of the first qualifying event;
- As a limited exception to the above, if you become disabled, as defined by the COBRA law, at the time of that qualifying event, and you notify the COBRA administrator or Metro of that fact during the 18-month COBRA Continuation Coverage period, you will be eligible for an additional eleven (11) months of COBRA Continuation Coverage (i.e., a total of twenty-nine (29) months of Coverage).

Termination of COBRA Continuation Coverage
After you have elected COBRA Continuation Coverage, that Coverage will terminate either at the end of the applicable 18, 29 or 36 month eligibility period or, before the end of that period, upon the date that:

- Payment for such Coverage is not submitted when due; or
- You become Covered as either a Subscriber or dependent by another group health care plan, and that coverage is as good as or better than the COBRA Continuation Coverage; or
- The ASA is terminated; or
- You become entitled to Medicare Coverage; or
- The date that you, otherwise eligible for twenty-nine (29) months of COBRA Continuation Coverage, are determined to no longer be disabled for purposes of the COBRA law.

CONTINUED COVERAGE DURING A LEAVE OF ABSENCE
Federal law requires that Metro allow Subscribers to continue their Coverage during a leave of absence. Please check with the Human Resources Department to find out how long Subscribers may take a leave of absence.

Subscribers also have to meet these criteria to have continuous Coverage during a leave of absence:

- Metro continues to consider the Subscriber an Employee, and all other Employee benefits are continued;
- The leave is for a specific period of time established in advance; and
- The purpose of the leave is documented.

A Subscriber may apply for COBRA Continuation if the leave lasts longer than allowed by Metro.

LEAVE OF ABSENCE

A "leave of absence" will be defined for purposes of this document as any approved or non-approved leave whereby the Employee's employment has not been terminated but the Employee is no longer being paid on the Metro payroll, or is carried on the Metro payroll but is not receiving compensation. Special provisions apply to Employees on Family and Medical Leave ("FMLA"), short term disability ("STD") and military leave. These provisions are described in separate sections, below. The following provisions apply to people on other types of leave of absence. A person will not be considered being on a leave of absence status if the Employee is receiving pay for vacation, compensatory time, sick leave, or such other type of pay including payment from a pension Plan administered by the Board. While on leave of absence, coverage will continue until the Employee has gone two consecutive pay periods without the full amount of the required employee contribution being withheld from his or her pay. Coverage under the plan will terminate on the date such second pay check would have been issued. However, an Employee, or Dependent(s) of an Employee who is on an approved or unapproved leave of absence, has the right to continue his coverage with the Plan. The guidelines under which the Covered Persons may continue coverage are those guidelines outlined for COBRA above. If a Covered Person wishes to continue coverage, they must follow the COBRA guidelines. COBRA coverage, if elected, will be effective as of the date the Employee's coverage under the plan terminates.

The Covered Person may elect not to continue coverage while on a leave of absence. If the Covered Person has not elected coverage through COBRA within the time frames outlined in the COBRA section, Human Resources will assume the Covered Person does not wish to continue medical coverage.

If the Covered Person does not elect to continue coverage while on a leave of absence, benefits will cease. When the Employee returns from the leave of absence, the Employee's coverage will automatically be reinstated by Human Resources (see Effective Date after Leave of Absence on page 61). Coverage will be reinstated for the Employee and Dependents with the same coverage and with the same health care Plan that the Employee had before the leave began, as long as the Employee and Dependents still meet the eligibility rules. However, the Employee will be allowed to transfer to another health care Plan when he returns from leave if the Employee was on leave during the Annual Enrollment period.

Coverage through the Plan while on a leave of absence may not exceed the amount of time allowed under the provisions of COBRA.

FAMILY MEDICAL LEAVE ACT COVERAGE

During a leave covered by the Family and Medical Leave Act, coverage under the Plan continues at the contribution rate that you would have paid had you remained active. Please contact your department's Human Resources Representative regarding how to pay for contributions while you are on leave.

If your FMLA will be unpaid (or a portion of it will be unpaid), you have the option of paying your contributions in one of the three (3) ways:

- pre-pay contributions prior to your FMLA or Short-Term Disability beginning;
- pay contributions directly to Metro on a month-by-month basis while on leave; or,
- have contributions held in arrears and when you return to work, contributions will be withheld from your paychecks.

If an election is not made and you are no longer in a paid status, your contributions will held in arrears and will be collected when you return to work.

SHORT TERM DISABILITY

While you are receiving Short-Term Disability (STD) benefits, your medical benefits will be continued and you will pay the same rate that you paid when you were actively working. Contributions will be withheld from your Metro paycheck as long as you are in a paid status. If your STD leave or a portion of your leave will be unpaid, you have the option of paying your contributions in one of three (3) ways:

- Pre-pay contributions prior to your FMLA or STD beginning;
- Pay contributions directly to Metro on a month-by-month basis while on leave; or,
- Have contributions held in arrears and when you return to work, contributions will be withheld from your paychecks.

If an election is not made and you are no longer in a paid status, your contributions will held in arrears and will be collected when you return to work.

MILITARY LEAVE

While you are on military leave, your medical benefits may be continued for up to 24 months and you will pay the same rate that you paid when you were actively working. Contributions will be withheld from your Metro paycheck as long as you are in a paid status. If your military leave will be unpaid, you have the option of paying your contributions in one of three (3) ways:

- Pre-pay contributions prior to your leave beginning;
- Pay contributions directly to Metro on a month-by-month basis while on leave; or,
- Have contributions held in arrears and when you return to work, contributions will be withheld from your paychecks.

If an election is not made and you are no longer in a paid status, your contributions will be held in arrears and will be collected when you return to work.

ELECTED OFFICIALS

Elected officials who were participants in the Plan during the time they held office may elect to continue medical coverage provided they pay the full amount of the contribution without any

subsidy from Metro. Elected officials may continue coverage also on their Dependents provided they were covered during the elected official's tenure in office. Dependents may continue to participate in the Plan upon the elected official's becomes deceased if they were covered by the Plan during the life of the elected official (see Metropolitan Code Section 3.24.010). Elected officials who continue coverage, or Dependents who continue coverage after the elected official becomes deceased, must elect coverage through Human Resources within sixty (60) calendar days of when their coverage would otherwise terminate with the Plan.

Elected officials who retire from Metro and receive a pension check will pay the contribution established by the Board for Pensioners.

All elected officials who continue their coverage will follow the administrative guidelines established in this Plan document for Pensioners.

PENSIONERS

A Regular Pensioner may elect to continue coverage with the Plan upon service retirement. Disability Pensioners are required to maintain coverage through the Plan unless they opt out of the Plan with proof of other coverage. However, a Disability Pensioner may elect not to continue coverage when he or she converts to a service pension or at the time he or she is eligible to convert to a service pension. When a Regular Pensioner elects a survivor's option under the Metro Pension Plan and the Regular Pensioner elects not to have medical coverage or elects to opt out with proof of other non-Medicare coverage, the medical coverage will be discontinued only if the surviving spouse/domestic partner also agrees in writing with the election not to have medical coverage. The surviving spouse/domestic partner must agree only when the survivor is an eligible Dependent (spouse/domestic partner) under the Plan's guidelines.

Pensioners must be receiving a monthly pension check from Metro to be eligible to continue coverage with the Plan.

Retired Members and surviving spouses of the Old Davidson County Board of Education Pension Plan are eligible to maintain the medical benefits (at the same rate paid by all other Pensioners) and provisions of this Medical Plan Document.

To continue coverage while on pension, the Pensioner must complete the appropriate forms in Human Resources at the time the Pensioner completes his pension application or prior to the Effective Date of the pension. The Pensioner, at that time, may add eligible Dependents to his coverage and change from Individual to Family coverage. The Pensioner will be allowed to add Dependents at a later date only under the very limited conditions specified in "Eligibility" section. The Pensioner must continue coverage with the same health care Plan when retiring but may change to other health care Plans, if available, during the Annual Enrollment period.

In the event of the death of a Pensioner, the covered Dependents may continue coverage if the Dependents as specified above in the "Eligibility" section meet the eligibility guidelines and completes the appropriate forms.

Upon retirement, if the Pensioner's spouse/domestic partner is an active Employee participating in the Plan, the Pensioner may elect to transfer his medical coverage to the active Employee's coverage and continue coverage as a Dependent.

Employees who have retired but will not be receiving a pension benefit check are not eligible to continue the Plan as a Pensioner, but may be eligible to continue coverage through other provisions of COBRA.

If a Pensioner who has continued coverage with the Plan returns to work with Metro and becomes eligible for coverage as an Employee, the Pensioner's status for insurance purposes will be transferred from a Pensioner to an Employee the day the Pensioner returns to work with Metro. If the Pensioner did not continue coverage as a Pensioner, the Pensioner will be treated for insurance purposes when he returns to work with Metro, as a newly eligible Employee.

If a Pensioner's pension ends for whatever reason, the Pensioner and his covered Dependents will not be allowed to continue coverage with the Plan as a Pensioner. The Pensioner and his Dependents may be allowed to continue coverage through COBRA depending on the amount of time that has expired as a Pensioner in comparison to the time limitations specified under COBRA.

PENSION BENEFICIARY

If an Employee dies before he or she goes on pension, the Employee's beneficiary on the Pension Plan may be eligible to be covered under this Plan. The term "Beneficiary" for the purposes of this Section will be defined as "the person that will receive survivor pension benefits from the Metro Pension Plan due to the death of a Metro Employee".

To qualify for coverage, the Beneficiary must meet the following criteria:

- At the time of death, the Employee must have been eligible for pension benefits due to years worked (service pension) or due to an in the-line-of-duty Injury or Illness;
- The Beneficiary must be receiving a monthly survivor's benefit check from the Metro Pension Plan; and,
- The Beneficiary must be a Dependent, as defined by this Plan, of the deceased Employee

The Beneficiary did not have to be covered by the Plan as a Dependent when the Employee died to be eligible for coverage as the Beneficiary.

The Beneficiary must complete the appropriate insurance forms in Human Resources at the time the Beneficiary completes the pension forms to receive the survivor's benefit. At that time, the Beneficiary may add other eligible Dependents to the Beneficiary's coverage and be covered under family coverage as long as they are Dependents (as defined by the Plan) of the deceased Employee. The Beneficiary must add eligible Dependents at this time because Dependents may not be added to coverage at a later date under any circumstances.

Once the Beneficiary meets the criteria outlined in this Section, the Beneficiary will follow the administrative guidelines established in this Plan document for Pensioners, unless otherwise specified.

The Beneficiary may continue coverage with the Plan as long as the Beneficiary qualifies for a survivor's benefit under the Metro Pension Plan. Once the Beneficiary becomes ineligible for the survivor's benefit, coverage under the Plan will terminate.

BENEFITS AFTER COVERAGE ENDS

Benefits for Hospital Services will be provided where a Member is hospitalized on the date this Plan is terminated, in which case benefits for Hospital Services only will be provided for up to 90 days or until the Member is discharged, whichever occurs first. The provisions of this Paragraph will not apply to a newborn child of a Subscriber for whom application for coverage was not received by the Plan within sixty (60) calendar days following such child's birth.

SECTION IX — DEFINITION OF TERMS

Actively at Work – The term actively at work means the performance of all of an Employee's regular duties for Metro on a regularly scheduled workday at the location where such duties are normally performed. An Employee will be considered to be Actively at Work on a non-scheduled work day (which would include a regularly scheduled vacation day) only if he or she was Actively at Work on the last regularly scheduled workday. An Employee who is not at work due to a health-related factor shall be treated as Actively at Work for purposes of determining eligibility. If it is determined, the Employee was not Actively at Work on the date coverage should have begun, the Effective Date of Coverage will be delayed until the date the Employee meets the definition of Actively at Work.

Acute – An illness or injury which is both severe and of short duration.

Administrative Services Agreement (ASA) – The agreement between Cigna and the Metro Government. It includes the ASA and any attached papers or riders (including the Letter of Intent, if any).

Bed and Board – The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Case Management – A process directed at linking individual Members and families with the appropriate medical services and community resources necessary to manage the Member's total care to promote optimum quality and an optimum outcome. Case Management involves a systematic process of assessing, planning, service coordination and monitoring through which multiple health needs of patients are met.

Change in Family Status – A change in circumstances to an Employee that would permit the Employee to revoke an election under a cafeteria plan as defined in Section 125 of the Internal Revenue Code. A Change in Family Status includes (a) "Special Enrollment Events" as described in the Enrolling in Coverage for Employees and their Dependents section above and the Enrolling in Coverage for Pensioners and their Dependents section above and (b) change in status events, including, change in legal marital status, number of Dependents, employment status, Dependent satisfying or ceasing to satisfy eligibility requirements, or residence.

Charges – The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount.

Chiropractic Care – The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Co-insurance – The amount stated as a percentage of the Maximum Allowable Charge for a Covered Service that is the responsibility of the Member during the Benefit Period after any Deductible has been satisfied.

The Member will be responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service if a Non-Network Provider's Billed Charges are more than the Maximum Allowable Charge for Services. In such case, the Member's total payment as

a percentage of the Non-Network Provider's Billed Charges may exceed the Co-insurance Payment percentage set forth in the Schedule of Benefits.

Covered Service – A Medically Necessary service or supply (specified in this Plan) for which benefits may be available.

Creditable Coverage – Individual or group health coverage of the Member prior to his or her Enrollment Date which may be applied to reduce a Member's Pre-existing Condition Waiting Period, if any, stated in this plan. Creditable Coverage also includes coverage under COBRA, a health maintenance organization, Medicare, Medicaid (including TennCare), the Federal Employee Health Benefit Plan, and/or a public, government, military or Indian Health Service benefit program.

Up to eighteen (18) months of Creditable Coverage may be applied to reduce the Member's applicable Pre-existing Condition Waiting Period. However, a period of coverage will not be counted for purposes of reducing a Member's Pre-existing Condition Waiting Period if there is a break in such coverage of sixty-three (63) days or more during which the Member was not covered under any Creditable Coverage.

Custodial Services – Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient **cannot care for himself or herself. Custodial Services include but are not limited to:**

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Deductible – The amount of Covered Services specified in the Schedule of Benefits that must be incurred and paid by a Member before Co-insurance benefits are paid. The Deductible will apply to the Out-of-Pocket Maximum.

Dependent – Dependents shall include only the following:

- Legally recognized spouse in accordance with the laws of the State of Tennessee, while not divorced or legally separated from the Subscriber;
- Domestic partner and his or her children as outlined in the Domestic Partnership Benefits Policy approved by the Board and where a Declaration of Domestic Partnership has been completed and acknowledged by Metro Human Resources;
- Natural and adopted children of the Subscriber who may or may not reside in the home of the Subscriber the majority of the time on an annual basis;

- "Foster child" means a child living in the residence of an eligible Subscriber in accordance with "Foster care placement" which means and is defined as the supervised adoption period prior to final adoption, as approved by a court of competent jurisdiction;
- A child of Subscriber or Subscriber's spouse/domestic partner for whom a Qualified Medical Child Support Order has been issued; or
- Step-children of the Subscriber and
- Children, other than those listed above, who are in the Subscriber's legal custody by court order

Dependent children, as defined above, will be covered from birth until the last day of the month of their twenty-sixth (26th) birthday, married or unmarried.

If on the child's twenty-sixth (26th) birthday, he is Incapacitated, which is defined as incapable of self-sustaining employment by reason of mental retardation or physical handicap, the child shall continue to be deemed a Dependent after said birthday, during the continuation of said incapacity and while he is otherwise included as a Dependent under the above definition, subject to the other terms and conditions of this Plan and to the right of the Administrator to require proof of incapacity when claim is first made for benefits after said birthday, and proof once each year thereafter of the continuation of said incapacity.

Disability Pensioner – The term Disability Pensioner means a former Employee receiving disability benefits from Metro and who meets the eligibility requirements provided herein.

Durable Medical Equipment – Equipment which:

- Can only be used to serve the medical purpose for which it is prescribed;
- Is not useful to the patient or other person in the absence of illness, injury or disability;
- Is able to withstand repeated use; and
- Is appropriate for use within the home

Such equipment will not be considered a Covered Service, even if it is prescribed by a Physician or Other Provider, simply because its use has an incidental health benefit.

Effective Date – The date on which coverage of a Member begins under this Plan according to the Schedule of Eligibility.

Emergency Services – Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an

emergency.

Employee – A person who meets the Eligibility requirements for coverage under this Plan**.**

Employer – The term Employer, in general, refers to the Metropolitan Government of Nashville and Davidson County and any other entity which, with the approval of the Metropolitan Government of Nashville and Davidson County, adopts the Plan. The Employer has delegated its authority to make decisions under the Plan to the Metropolitan Employee Benefit Board created in accordance with Section 13.02 of the Metropolitan Charter ("Metro").

Enrollment Date – The Effective Date of a Member's coverage or, if earlier, the first day of the applicable Eligibility Waiting Period.

Expense Incurred – An expense is incurred when the service or the supply for which it is incurred is provided.

Explanation of Benefits (EOB) – The form we send after a claim has been filed that tells you what services were covered and which, if any, were not.

Free-Standing Surgical Facility – The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

HRA Fund Amount – The amount Metro contributes to a Member's Health Reimbursement Arrangement (HRA) Fund each plan year.

Hospice Care Program – The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services – The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

Hospice Facility – The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

Hospital – The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

  The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital – A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

Injury – The term Injury means an accidental bodily injury.

Late Enrollee – An Employee or eligible Dependent who did not apply, or for whom application was not made, for coverage within 60 calendar days after such person first became eligible for coverage under this Plan.

Limiting Age (or Dependent Child Limiting Age) – The age after which a child will no longer be considered an eligible Dependent.

Maintenance Treatment – The term Maintenance Treatment means treatment rendered to keep or maintain the patient's current status.

Maximum Allowable Charge – The amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based

upon the Plan's contract with a Network Provider or the amount payable based on the Administrator's fee schedule for the Covered Services.

Maximum Reimbursable Charge – Medical – The Maximum Reimbursable Charge for Covered Services is determined based on the lesser of:

- The provider's normal charge for a similar service or supply; or
- A policyholder-selected percentage of a fee schedule developed by Cigna that is based upon a methodology similar to the methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

Medicaid – The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary/Medical Necessity (medically appropriate) – Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

Medicare – The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Member, You, Your – Any person enrolled as a Subscriber or Covered Dependent under the Plan.

Necessary Services and Supplies – The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Network Provider – An Institution, Physician, Outpatient mental health facility, Outpatient physical therapy facility, Home Health Agency, Pharmacy, Physician, or Other Provider of health care services, which, at the time a Member receives Covered Services has an agreement with Cigna to provide those health care services to Members under this Plan. A Network Provider may bill or seek reimbursement for Authorized Services from Cigna, except for the Member's Deductibles or Co-insurance amounts.

Non-Network Pharmacy – A pharmacy other than a Participating Pharmacy.

Non-Network Provider – A Physician, Hospital, or Other Provider that has not contracted with Cigna to furnish services and to accept Cigna's payment, plus applicable Deductibles, as payment in full for Covered Services.

Nurse – The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Other Health Care Facility – The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

Other Health Professional – The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses

Out of Pocket Maximum – The dollar amount stated in the Schedule of Benefits for which a Member is responsible for Covered Services during a Benefit Period. When the Out-Of-Pocket Maximum is reached, 100% is payable for other Covered Services received from a Network Provider during the remainder of the Benefit Period. However, the Non-Network Out-Of-Pocket Maximum must be reached before 100% is payable for other Covered Services received from a non-Network Provider during the remainder of the Benefit Period.

Participating Pharmacy – The term Participating Pharmacy means a retail pharmacy with which Cigna has contracted to provide prescription services to insureds; or a designated mail-order pharmacy with which Cigna has contracted to provide mail-order prescription services to insureds.

Participating Provider – The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services with regard to a particular plan under which the participant is covered.

Pharmacy – The term Pharmacy means a retail pharmacy, or a mail-order pharmacy.

Physician – The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Prescription Drug – Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Order – Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

Preventive Care or Treatment – The term Preventive Care or Treatment means treatment rendered to prevent disease or its recurrence.

Prior Authorization or Authorization – A review conducted by the Plan, prior to the delivery of certain services, to determine if such services will be considered Covered Services.

Primary Care Physician – The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your insured Dependents.

Psychologist – The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.

Regularly employed – Regularly employed means you are working a minimum of 20 hours per week. Accordingly, you are considered Regularly Employed if you are: (a) a nine (9) month Employee scheduled to work 780 hours or more during a calendar year; (b) a ten (10) month Employee scheduled to work 860 hours or more during a calendar year; or (c) a twelve (12) month Employee scheduled to work 1040 hours or more during a calendar year.

Regular Pensioner – A former Employee, or a survivor of a former Employee, who has retired and is receiving a pension from Metro. Employees (i) hired on or after January 1, 2013 or (ii) rehired on or after January 1, 2013 who had not earned a vested right to a pension in accordance with the Metropolitan Code of Laws prior to the date of rehire, must be eligible for an immediate service pension (early or normal – whether they chose to defer the pension or not) at the time of their employment termination in order to be eligible to keep their medical benefits as a Regular Pensioner. Contributions will be payable in accordance with provisions outlined in the Metropolitan Code and approved by the Board.

Related Supplies – Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

Review Organization – The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

Sickness – For Medical Insurance – The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility – The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

Subscriber – An Employee or Pensioner who has satisfied the eligibility requirements and has been enrolled for coverage under this Plan.

Terminal Illness – A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Two Quarter Rule – If you are not Regularly Employed, but average 20 hours or more per week in each of two consecutive quarters, you will become eligible for coverage during the following quarter under the Two Quarter Rule. If you do not average 20 or more hours per week in each of two consecutive quarters, you will become ineligible for coverage in the following quarter under the same rule.

Urgent Care – Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

SECTION X – NOTICES

COVERAGE FOR MATERNITY HOSPITAL STAY

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the "Newborns' and Mothers' Health Protection Act": 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 cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.
Please review this Plan for further details on the specific coverage available to you and your Dependents.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994

You may continue your Coverage and Coverage for your Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When you return to work from your military leave of absence, you will be given credit for the time you were covered under the Plan prior to the leave. Check with Metro to see if this provision will apply to you.

SECTION XI –PRIVACY PRACTICES

PROVISION OF PROTECTED HEALTH INFORMATION TO COMPANY

The provisions of this section to the CIGNA Choice Fund Open Access Plus Medical Plan for The Metropolitan Government of Nashville and Davidson County are supplemental to and controlling over any inconsistent terms of the Plan. It is intended to comply with the requirements of the privacy and security regulations promulgated under HIPAA regarding information that can be disclosed by the Plan to Company.

I. DEFINITIONS

The following terms shall have the meanings described in this paragraph I when capitalized. Other capitalized terms will have the meanings described in the Plan:

- **Administrator** - The committee, individual or individuals appointed by Metro to administer the Plan and to perform on behalf of the Plan those duties or actions specified in this Addendum
- **Electronic Protected Health Information or EPHI** - Electronic Protected Health Information as defined in 45 C.F.R. § 160.103
- **HIPAA** - The Health Insurance Portability and Accountability Act of 1996, as amended
- **Plan** - The Metropolitan Government of Nashville and Davidson County CIGNA Choice Fund Open Access Plus Medical Plan for The Metropolitan Government of Nashville and Davidson County and its agents, health insurance issuer or Open Access Plan,
- **Privacy Regulations** - The regulations contained in 45 C.F.R. Parts 160 and 164
- **Protected Health Information or PHI** - Protected health information as defined in 45 C.F.R. 164.501, which is created or received by the Plan relating to a Participant
- **Required by Law** - Required by law as defined in 45 C.F.R. § 164.501
- **Security Incident** - Security incident as defined in 45 C.F.R. § 164.304
- **Security Regulations** - The regulations contained in 45 C.F.R. Parts 160, 162 and 164
- **Summary Health Information** - Summary health information as defined in 45 C.F.R. § 164.504(a) that is created or received by the Plan

II. PERMITTED DISCLOSURE OF ENROLLMENT/DISENROLLMENT INFORMATION

The Plan may disclose to Metro information on whether an Employee or their Dependents are participating in the Plan, or are enrolled in or have disenrolled from a health insurance issuer or Open Access Plus offered by the Plan.

III. PERMITTED USES AND DISCLOSURE OF SUMMARY HEALTH INFORMATION

The Plan may disclose Summary Health Information to Metro, if Metro requests the Summary Health Information for the purpose of (a) obtaining contribution bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

IV. PERMITTED AND REQUIRED USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PLAN ADMINISTRATIVE PURPOSES

Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph V and obtaining written certification pursuant to paragraph VII, the Plan may disclose PHI to Metro, provided Metro uses or discloses such PHI only for Plan Administration Purposes. As used in this paragraph, "Plan Administration Purposes or Functions" means administration functions performed by Metro on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by Metro in connection with any other benefit or benefit plan of Metro, and they do not include any employment-related functions. Notwithstanding the provisions of this Addendum to the contrary, in no event shall Metro be permitted to use or disclose PHI in a manner that is inconsistent with 45 C.F.R. § 164.504(f).

V. CONDITIONS OF DISCLOSURE FOR PLAN ADMINISTRATION PURPOSES

Metro agrees that with respect to any PHI (other than enrollment/disenrollment information, Summary Health Information and information authorized under paragraph VIII) disclosed to it by the Plan, that Metro shall:

- Not use or further disclose PHI other than as permitted or required by the Plan or as Required by Law;
- Ensure that any agents, including a subcontractor, to whom Metro provides PHI received from the Plan agree to the same restrictions and conditions that apply to Metro with respect to PHI;
- Not uses or discloses PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of Metro;
- Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which Metro becomes aware;
- Make available PHI to comply with HIPAA's right to access in accordance with 45 C.F.R. § 164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

- Make Metro's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining compliance by the Plan with the Privacy Regulations;
- If feasible, return or destroy all PHI received from the Plan that Metro still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation between Plan and Metro required by 45 C.F.R. § 504(f) (2) (iii) and described in paragraph VI, is satisfied

VI. ADEQUATE SEPARATION BETWEEN PLAN AND METRO

Metro shall allow the Central HR Benefit Services Division, Benefit Board Support Staff, Benefit Administrative Staff which includes Assistant HR Director, Deputy Director – HR, and HR Director as well as the HIPAA privacy officer access to PHI. No other persons shall have access to PHI. These Employees or classes of Employees specified in this paragraph shall only have access to and use PHI to the extent necessary to perform the Plan Administration Functions that Metro performs for the Plan. In the event that any of these specified Employees do not comply with the provisions of this Addendum, that Employee shall be subject to disciplinary action by Metro for non-compliance pursuant to Metro's Employee discipline and termination policies established pursuant to the Privacy Regulations.

VII. CERTIFICATION OF COMPANY

The Plan shall disclose PHI to Metro only upon the receipt of a certification by Metro that the Plan has been amended to incorporate the provisions of 45 C.F.R. § 164.504(f) (2) (ii), and that Metro agrees to the conditions of disclosure set forth in paragraph IV of this Amendment.

VIII. PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION AUTHORIZED BY A PARTICIPANT

The Plan may disclose Protected Health Information about a Participant in accordance with an authorization executed by the Participant that complies with 45 C.F.R. § 164.508 and to the extent permitted by the Privacy Regulations.

IX. REQUIREMENTS RELATED TO SECURITY REGULATIONS

By the Effective Date of the Security Regulations, Metro shall with respect to any EPHI (except when the only EPHI disclosed to Metro is disclosed pursuant to paragraphs II, III and VIII):

- Implement administrative, physical, and technical safeguards that reasonably and appropriately Protect the confidentiality, integrity, and availability of the EPHI that Metro creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation required by 45 C.F.R. § 164.504(f) (2) (iii) and described in paragraph VI is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom Metro provides EPHI agrees to implement reasonable and appropriate security measures to protect the EPHI; and Report to the Plan any Security Incident of which Metro becomes aware.

SECTION XII – COORDINATION OF BENEFITS

COORDINATION OF BENEFITS

This plan document includes the following Coordination of Benefits (COB) provision, which applies when a Member has coverage under more than one group contract or health care "Plan." Rules of this Section determine whether the benefits available under this plan document are determined before or after those of another Plan. In no event, however, will benefits under this plan document be increased because of this provision.

If this COB provision applies, the order of benefits determination rules should be looked at first. Those rules determine whether the Plan's benefits are determined before or after those of another Plan.

1. **Definitions**. The following terms apply to this provision:

   a. "Plan" means any form of medical or dental coverage with which coordination is allowed. "Plan" includes:

      (1) group, blanket, or franchise insurance;

      (2) a group Cigna Plan;

      (3) group or group-type coverage through HMOs or other prepayment, group practice and individual practice plans;

      (4) coverage under labor management trust Plans or employee benefit organization Plans;

      (5) coverage under government programs to which an employer contributes or makes payroll deductions;

      (6) coverage under a governmental Plan or coverage required or provided by law;

      (7) medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type coverages;

      (8) coverage under Medicare and other governmental benefits; and

      (9) any other arrangement of health coverage for individuals in a group.

   b. "Plan" does not include individual or family:

      (1) Insurance contracts;

      (2) Subscriber contracts;

      (3) Coverage through Health Maintenance (HMO) organizations;

      (4) Coverage under other prepayment, group practice and individual practice plans;

      (5) Public medical assistance programs (such as TennCare[sm]);

(6) Group or group-type hospital indemnity benefits of $100 per day or less;

(7) School accident-type coverages.

Each Contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply to only one of the two, each of the parts is a separate Plan.

c. "This Plan" refers to the part of the employee welfare benefit plan under which benefits for health care expenses are provided.

"Other Plan" applies to each arrangement for benefits or services, as well as any part of such an arrangement that considers the benefits and services of other contracts when benefits are determined.

d. “Primary Plan/Secondary Plan”.

(1) The order of benefit determination rules state whether This Plan is a "Primary Plan" or "Secondary Plan" as to another plan covering you.

(2) When This Plan is a Primary Plan, its benefits are determined before those of the Other Plan. We do not consider the Other Plan's benefits.

(3) When This Plan is a Secondary Plan, its benefits are determined after those of the Other Plan and may be reduced because of the Other Plan's benefits.

(4) When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more Other Plans, and may be a Secondary Plan as to a different Plan or Plans.

e. "Allowable Expense" means a necessary, reasonable and customary item of expense when the item of expense is covered at least in part by one or more Plans covering the Member for whom the claim is made.

(1) When a Plan provides benefits in the form of services, the reasonable cash value of a service is deemed to be both an Allowable Expense and a benefit paid.

(2) We will determine only the benefits available under This Plan. You are responsible for supplying us with information about Other Plans so we can act on this provision.

f. "Claim Determination Period" means a Calendar Year. However, it does not include any part of a year during which you have no coverage under This Plan or any part of a year prior to the date this COB provision or a similar provision takes effect.

g. "Complying Plan" is a plan that has a coordination of benefit’s provision that complies with either Tennessee’s state regulation on coordination of benefits or the National Association of Insurance Commissioners proposed coordination of benefits language. In addition, a Complying Plan’s coordination of benefits provision is designed in such a

manner that it can coordinate benefits between plans with similar coordination of benefits terms.

2. **Order of Benefit Determination Rules**. This Plan determines its order of benefits using the first of the following rules that applies:

   a. Non-Dependent/Dependent

      The benefits of the Plan that covers the person as an Employee, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent, except that:

      (1) if the person is also a Medicare beneficiary and,

      (2) if the rule established by the Social Security Act of 1965 (as amended) makes Medicare secondary to the Plan covering the person as a Dependent of an active Employee, then the order of benefit determination shall be:

         i. benefits of the Plan of an active Employee covering the person as a Dependent;

         ii. Medicare;

         iii. benefits of the Plan covering the person as an Employee, Member, or Subscriber.

   b. Dependent Child/Parents Not Separated or Divorced

      Except as stated in Paragraph (c) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":

      (1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

      (2) If both parents have the same birthday, the benefits of the Plan that has covered one parent longer are determined before those of the Plan that has covered the other parent for a shorter period of time.

      (3) However, if the Other Plan does not have the rule described immediately above, but instead has a rule based upon 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.

   c. Dependent Child/Separated or Divorced Parents

      If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

      (1) First, the Plan of the parent with custody of the child;

      (2) Then, the Plan of the spouse of the parent with the custody of the child; and

(3) Finally, the Plan of the parent not having custody of the child.

(4) However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(5) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph 2(b), Dependent Child/Parents Not Separated or Divorced.

d. Active/Inactive Employee

The benefits of a Plan that covers a person as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired Employee. If the Other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule is ignored.

e. Longer/Shorter Length of Coverage

If none of the above Rules determines the order of benefits, the benefits of the Plan that has covered an Employee, Member, or Subscriber longer are determined before those of the Plan that has covered that person for the shorter term.

(1) To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

(2) The start of the new Plan does not include:

i. A change in the amount of scope of a Plan’s benefits;
ii. A change in the entity that pays, provides or administers the Plan’s benefits;
iii. A change from one type of Plan to another (such as, from a single Employer Plan to that of a multiple Employer plan).

(3) The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a Member of the Group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

If the Other Plan does not contain provisions establishing the Order of Benefit Determination Rules, the benefits under the Other Plan will be determined first.

f. Plans with Excess and Other Non-conforming COB Provisions

Some Plans declare their coverage "in excess" to all Other Plans, "always Secondary," or otherwise not governed by COB rules. These Plans are called "Non-complying Plans."

Rules. This Plan coordinates its benefits with a Non-complying Plan as follows:

(1) If This Plan is the Primary Plan, it will provide its benefits on a primary basis.

(2) If This Plan is the Secondary Plan, it will provide benefits first, but the amount of benefits and liability of This Plan will be limited to the benefits of a Secondary Plan.

(3) If the Non-complying Plan does not provide information needed to determine This Plan's benefits within a reasonable time after it is requested, This Plan will assume that the benefits of the Non-complying Plan are the same as the benefits of This Plan and provide benefits accordingly. However, this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Non-complying Plan.

(4) If:

(a) The Non-complying Plan reduces its benefits so that the Member receives less in benefits than he or she would have received had the Complying Plan paid, or provided its benefits as the Secondary Plan, and the Non-complying Plan paid or provided its benefits as the Primary Plan; and

(b) Governing state law allows the right of subrogation set forth below;

then the Complying Plan shall advance to you or on your behalf an amount equal to such difference. However, in no event shall the Complying Plan advance more than the Complying Plan would have paid, had it been the Primary Plan, less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all your rights against the Non-complying Plan. Such advance by the Complying Plan shall also be without prejudice it may have against the Non-complying Plan in the absence of such subrogation.

3. **Effect on the Benefits of this Plan**. This provision applies where there is a basis for a claim under This Plan and the Other Plan and when benefits of This Plan are determined as a Secondary Plan.

a. Benefits of This Plan will be reduced when the sum of:

(1) the benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision; and

(2) the benefits that would be payable for the Allowable Expenses under the Other Plan(s), in the absence of provisions with a purpose similar to that of this COB provision, whether or not a claim for benefits is made;

exceeds Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plan(s) do not total more than Allowable Expenses.

b. When the benefits of This Plan are reduced as described above, each benefit is reduced proportionately and is then charged against any applicable benefit limit of This Plan.

c. The administrator will not, however, consider the benefits of the Other Plan(s) in determining benefits under This Plan when:

(1) the Other Plan has a rule coordinating its benefits with those of This Plan and such rule states that benefits of the Other Plan will be determined after those of This Plan; and

(2) the order of benefit determination rules requires us to determine benefits before those of the Other Plan.

4. **Right to Receive and Release Needed Information**.

Certain facts are needed to apply these COB rules. We have the right to decide which facts we need. To the extent permitted by applicable laws, including HIPAA, we may get needed facts from, or give them to any other organization or person, and we need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to pay the claim.

5. **Facility of Payment**.

A payment under Another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made that payment. That amount would then be treated as if it were a benefit paid under This Plan. We will not have to pay that amount again. The term "Payment Made" includes providing benefits in the form of services; in which case, Payment Made means reasonable cash value of the benefits provided in the form of services.

6. **Right of Recovery**.

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

a. The persons it has paid or for whom it has paid;

b. Insurance companies; or

c. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION WITH MEDICARE

This provision applies when benefits are available under this Plan and Medicare, and if Medicare is the primary plan. Benefits will be reduced under this Plan so that the sum of the benefits payable under both this Plan and Medicare will not be more than the total amount covered under this Plan. Payments by this Plan will be based on Medicare allowance. This provision applies for Members who retired from Metro after October 1, 1993. If a Pensioner who is eligible for Medicare does not elect both Parts A and B of Medicare, benefits will be reduced by this Plan and benefits will be provided for Part B at 20% of billed charges.

COORDINATION OF BENEFITS – END STAGE RENAL DISEASE

This provision applies when benefits are available under this Plan and benefits are also available under Medicare because a participant has End Stage Renal Disease ("ESRD"). Medicare has special Coordination of Benefits rules for individuals covered by virtue of ESRD who are also covered by an employer group health plan. Under the terms of the Medicare rules and this Plan, during the 30 months after a Member is eligible for Medicare, the Plan is the Primary plan and Medicare is the Secondary plan. After the 30 month period, Medicare becomes the Primary plan for individuals and the Plan becomes the Secondary Plan. Under the Plan, benefits are determined and paid as if the Member with ESRD has enrolled in Medicare even if the Member has not enrolled in Medicare. A Member who enrolls in Medicare can enroll after becoming eligible for Medicare but must enroll before the 30-month period that commences upon Medicare eligibility to avoid paying higher premiums to Medicare. The Member must pay the Part B premium.

Once Medicare becomes the Primary plan, the employee contribution may be changed to reflect the fact that Medicare is the Primary payer. Please see Medicare's rules to determine when you are eligible for Medicare by virtue of ESRD.

SECTION XIII — MISCELLANEOUS

SEVERABILITY

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or non-enforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

APPENDIX 1

The Benefit Board Of
The Metropolitan Government of Nashville and Davidson County
Grievance and Appeal Standard for Health Claims

Employees and, if applicable, their beneficiaries, must follow the procedures described in the applicable plan documents for filing claims and grievances or appeals in cases where claims have been denied.

The Administrator will apply the standards and procedures described below for adjudicating claims for Grievances and Level 1 Appeals. The Board will apply the standards and procedures described below for adjudicating claims for Level 2 Appeals.

Grievances

Level 1 Appeals

If a claim for benefits is denied in full or in part, the Administrator or its delegate will notify the claimant in writing within a reasonable period of time, but not later than 90 days after the claim is filed. If special circumstances require extra time for processing, the deadline may be extended for another 90 days. The claimant will be notified before the end of the initial 90-day review period of the reasons for the delay and the date by which he or she may expect a decision.

The claimant also will be notified of the standards used in determining benefit eligibility, the unresolved issues that prevent a decision on his or her claim, and the additional information needed to resolve those issues. The claimant will have at least 45 days to respond to the Administrator or its delegate's request for additional information.

If a claim is denied, the notice of denial will state the reasons for the denial and the plan provisions on which the denial is based. It also will inform the claimant of any additional information or material required to support his or her claim, why the information or material is necessary, and the procedure that must be followed to have the Administrator or its delegate review the denial of the claim.

If the claimant does not receive a notice of delay or a notice of denial within the applicable timeframe described above, or if the Administrator fails in a significant way to follow the procedures described above, the claimant can assume that the claim was denied and may proceed to the appeal stage described in the section below.

Level 2 Appeals

If a claim is denied (or if it is considered to have been denied because the claimant did not receive a written response from the Administrator by the applicable deadline), the claimant or his or her beneficiaries may write to the Board to appeal the denial. The claimant must appeal a denial within 60 days of receipt of the denial or it is deemed denied (i.e., the applicable deadline for the claimant having received a denial). The appeal should include an explanation of why the claimant thinks the denial is incorrect.

The claimant or his or her beneficiaries may see all documents, guidelines, and other materials that relate to the claim, submit any issues and comments in writing to the Board, and, if the claimant wishes, have someone act as his or her representative in the review procedure.

Appeals will be given a full and fair review by the Board.

If an appeal is denied, the Board must provide the claimant with written notice of this denial within a reasonable period of time, but not more than 60 days after receipt of the appeal. There may be times when this 60-day period has to be extended. However, this extension is allowed only when there are special circumstances, which must be communicated to the claimant in writing within the initial 60-day period. If there is an extension, a decision will be made as soon as possible, but not later than a total of 120 days after the Board receives the appeal.

The Board's final decision on an appeal will be communicated to the claimant in writing and will include the reason or reasons the appeal was denied.