Metropolitan Government of Nashville and Davidson County

PPO PLAN MEDICAL BENEFITS

Copay Plan

EFFECTIVE DATE: January 1, 2024

This document takes the place of any documents previously issued to you which described your benefits.

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Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

HC-NOT89

About This Document

This document is the official PPO Medical Plan document of the Metropolitan Government of Nashville & Davidson County administered by Cigna (the "Plan"). If there is a difference between this Plan and other documents that describe the Plan, this document will govern.

Any 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.

Plan Sponsor – Metropolitan Government of Nashville and Davidson County
Metro Human Resources
700 President Ronald Reagan Way, Suite 201
Nashville, TN 37210
Phone: 615-862-6700

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 appeal related to your Coverage under this Plan shall be resolved in accordance with appeal process noted in this 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, and travel expenses for organ transplants.

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*.

Explanation of Terms

You will find terms starting with capital letters throughout this plan document. To help you understand your benefits, most of these terms are defined in the Definitions section of this document.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Other Metro Nashville Medical Benefits

Metro offers additional medical options other than the benefits described in this Plan. Specifically, Metro also offers an HRA Plan as an option. Other medical coverage options are not discussed in this Plan.

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.

Plan Assets

This is a self-insured medical Plan and its assets are held in medical care benefits insurance account in accordance with Metropolitan Code Section 3.08.140. This Plan is funded by premium contributions collected from Metro, employees and pensioners and managed in a medical care benefits insurance account.

Termination of Plan and Its Assets

In the event of termination of this Plan, any assets remaining in the medical care benefits insurance account will be the sole property of the Metropolitan Government of Nashville and Davidson Country. There will be no Plan assets for distribution to any Members.

Special 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 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

The following pages describe helpful 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.

HC-SPP70 01-21

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.

HC-SPP2 04-10
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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.

HC-SPP3 04-10
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Incentives to Participating Providers

Cigna continuously develops programs to help our customers access quality, cost-effective health care. Some programs include Participating Providers receiving financial incentives from Cigna for providing care to members in a way that meets or exceeds certain quality and/or cost-efficiency standards, when, in the Participating Provider's professional judgment, it is appropriate to do so within the applicable standard of care. For example, some Participating Providers could receive financial incentives for utilizing or referring you to alternative sites of care as determined by your plan rather than in a more expensive setting, or achieving particular outcomes for certain health conditions. Participating Providers may also receive purchasing discounts when purchasing certain prescription drugs from Cigna affiliates. Such programs can help make you healthier, decrease your health care costs, or both. These programs are not intended to affect your access to the health care that you need. We encourage you to talk to your Participating Provider if you have questions about whether they receive financial incentives from Cigna and whether those incentives apply to your care.

HC-SPP85 01-24

Care Management and Care Coordination Services

Your plan may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing participants with certain care management and care coordination services to facilitate achievement of these goals. Reimbursement is provided at 100% for these services when rendered by designated health care professionals in these collaborative arrangements.

HC-SPP27 06-15
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Important Notices

Notice of Grandfathered Plan Status

This plan is being treated as 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 coverage 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 health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the phone number or address provided in your plan documents, to your employer or plan sponsor or an explanation can be found on Cigna's website at http://www.Cigna.com/sites/healthcare_reform/customer.html

Your plan is a nonfederal government plan or a church plan, you may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

HC-NOT4 01-11

Important Information

Rebates and Other Payments

Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals covered under your plan and Prescription Drug Products included on the Prescription Drug List. These rebates or remuneration are not obtained on you or your Employer's or plan's behalf or for your benefit.

Cigna, its affiliates and the plan are not obligated to pass these rebates on to you, or apply them to your plan's Deductible if any or take them into account in determining your Copayments and/or Coinsurance. Cigna and its affiliates or designees, conduct business with various pharmaceutical manufacturers separate and apart from this plan's Medical Pharmaceutical and Prescription Drug Product benefits. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this plan. Cigna and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, Cigna or its designee may send mailings to you or your Dependents or to your Physician that communicate a variety of messages, including information about Medical

Pharmaceuticals and Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you or your Dependents, at your discretion, to purchase the described Medical Pharmaceutical and Prescription Drug Product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Cigna, its affiliates and the plan are not responsible in any way for any decision you make in connection with any coupon, incentive, or other offer you may receive from a pharmaceutical manufacturer or Physician.

HC-IMP331 12-22

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HC-NOT96 07-17

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サー ビスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711را شماره‌گیری کنید).

HC-NOT97 07-17

Federal CAA - Consolidated Appropriations Act Coverage Notice

Pursuant to Consolidated Appropriations Act (CAA), Section 106, Cigna will submit certain air ambulance claim information to the Department of Health and Human Services (HHS) in accordance with guidance issued by HHS.

Subject to change based on government guidance for CAA Section 204, Cigna will submit certain prescription drug and health care spending information to HHS through Plan Lists Files (P1-P3) and Data Files (D1-D8) (D1-D2) for an Employer without an integrated pharmacy product aggregated at the market segment and state level, as outlined in guidance.

HC-IMP353 01-24

Federal CAA - Consolidated Appropriations Act

Continuity of Care

In certain circumstances, if you are receiving continued care from an In-Network provider or facility, and that provider's network status changes from In-Network to Out-of-Network, you may be eligible to continue to receive care from the provider at the In-Network cost-sharing amount for up to 90 days from the date you are notified of your provider's termination. A continuing care patient is an individual who is:

- Undergoing treatment for a serious and complex condition
- Pregnant and undergoing treatment for the pregnancy
- Receiving inpatient care
- Scheduled to undergo urgent or emergent surgery, including postoperative
- Terminally ill (having a life expectancy of 6 months or less) and receiving treatment from the provider for the illness

If applicable, Cigna will notify you of your continuity of care options.

Appeals

Any external review process available under the plan will apply to any adverse determination regarding claims subject to the No Surprises Act.

Provider Directories and Provider Networks

A list of network providers is available to you, without charge, by visiting the website or calling the phone number on your ID card. The network consists of providers, including Hospitals, of varied specialties as well as generic practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

A list of network pharmacies is available to you, without charge, by visiting the website or calling the phone number on your ID card. The network consists of pharmacies affiliated or contracted with Cigna or an organization contracting on its behalf.

Provider directory content is verified and updated, and processes are established for responding to provider network status inquiries, in accordance with applicable requirements of the No Surprises Act.

If you rely on a provider's In-Network status in the provider directory or by contacting Cigna at the website or phone number on your ID card to receive covered services from that provider, and that network status is incorrect, then your plan cannot impose Out-of-Network cost shares to that covered service. In-Network cost share must be applied as if the covered service were provided by an In-Network provider.

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, access the website or call the phone number on your ID card.

Selection of a Primary Care Provider

This plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, access the website or call the phone number on your ID card.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an Out-of-Network provider at an In-Network Hospital or ambulatory surgical center, you are protected from balance billing. In these situations, you should not be charged more than your plan's Copayments, Coinsurance, and/or Deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a Copayment, Coinsurance, and/or Deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-Network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-Network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**". This amount is likely more than In-Network costs for the same service and might not count toward your plan's Deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care – such as when you have an emergency or when you schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

- **Emergency Services** – If you have an Emergency Medical Condition and get Emergency Services from an Out-of-Network provider or facility, the most they can bill you is your plan's In-Network cost-sharing amount (such as a Copayments, Coinsurance, and Deductibles). You cannot be balanced billed for these Emergency Services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Certain non-emergency services at an In-Network Hospital or ambulatory surgical center –** When you get services from an In-Network Hospital or ambulatory surgical center, certain providers there may be Out-of-Network. In these cases, the most those providers can bill you is your plan's In-Network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may not ask you to give up your protections not to be balanced billed. If you get other types of services at these In-Network facilities, Out-of-Network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get Out-of-Network care. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you have these protections:

- You are only responsible for paying your share of the cost (such as Copayments, Coinsurance, and Deductibles that you would pay if the provider were In-Network). Your health plan will pay any additional costs to Out-of-Network providers and facilities directly.
- Generally, your health plan must:
  - Cover Emergency Services without requiring you to get approval in advance for services (also known as prior authorization).
  - Cover Emergency Services provided by Out-of-Network providers.

- Base what you owe the provider or facility (cost sharing) on what it would pay an In-Network provider or facility and show that amount in your explanation of benefits (EOB).
- Count any amount you pay for Emergency Services or Out-of-Network services toward your In-Network Deductible and out-of-pocket limit.

If you think you have been wrongly billed, contact Cigna at the phone number on your ID card. You can also contact No Surprises Help Desk at 1-800-985-3059 or www.cms.gov/nosurprises for more information about your rights under federal law.

HC-IMP326 01-24

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) - Non-Quantitative Treatment Limitations (NQTLs)

Federal MHPAEA regulations provide that a plan cannot impose a Non-Quantitative Treatment Limitation (NQTL) on mental health or substance use disorder (MH/SUD) benefits in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, those used in applying the NQTL to medical/surgical benefits in the same classification of benefits as written and in operation under the terms of the plan.

Non-Quantitative Treatment Limitations (NQTLs) include (to the extent applicable under the plan):

- medical management standards limiting or excluding benefits based on Medical Necessity or whether the treatment is experimental or investigative;
- prescription drug formulary design;
- network admission standards;
- methods for determining In-Network and Out-of-Network provider reimbursement rates;
- step therapy a/k/a fail-first requirements; and
- exclusions and/or restrictions based on geographic location, facility type or provider specialty.

A description of your plan's NQTL methodologies and processes applied to medical/surgical benefits and MH/SUD benefits is available for review by Plan Administrators (e.g. Employers) and covered persons:

Employers (Plan Administrators):
Please contact your Cigna Sales Representative to request the NQTL comparative analysis.
Covered Persons: www.cigna.com\sp

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How To File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by using the toll-free number on your identification card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

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Eligibility

Coverage for You

This Plan describes the benefits you may receive under the PPO 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" 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; or 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 intellectual or physical disability, 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.

The Dependent Child Limiting Age will be to age 26. When a Dependent's coverage terminates for reasons other than the Limiting Age, the Subscriber will be responsible for notifying Metro Human Resources. 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 eligibility under Medicare Parts A **and** B):

- Pensioner Only (Individual) – Covers the Pensioner, if the Pensioner does not have Medicare;
- Pensioner Family – Covers the Pensioner, Spouse/Domestic Partner and any other Eligible Dependent;
- Pensioner + Child(ren) – Covers the Pensioner and one or more eligible Dependent Child(ren) where none 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 with Medicare and Child (ren) without Medicare – covers Pensioner with Medicare and a dependent child (ren) without Medicare;
- Three Family Members Covered with Two of them having Medicare Parts A and B.
- Pensioner without Medicare and one Child with Medicare – covers Pensioner without Medicare and one Dependent Child who does have Medicare.

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 Termination, Reinstatement and Continuation of Coverage Section.

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 and you have not opted out of coverage in accordance with the Opt Out/Opt In policies adopted by the Board, 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 27) 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 27), (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;
- 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.
- Pensioners and eligible Dependents where all covered members are Medicare eligible, unless otherwise required by law.

Those Employees covered by the Plan, prior to August 1, 1990, that do not meet the eligibility criteria of the Plan 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 Employee has Employee +Child(ren0) coverage, Dependent Children may be added even if there is no Change in Family Status. The effective date of the added Dependent's 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 in 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 HRA 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, or 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 and 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 13.)

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 legally recognized spouse in accordance with the laws of the State of Tennessee 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 already 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 and Changes in Family Status

The types of changes that you are permitted to make as a Pensioner to you 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 non-Medicare 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.

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, Cigna encourages the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents. If you need assistance selecting your Primary Care Physician, please visit our website at www.cigna.com or call the number on the back of your ID Card.

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

You and your Dependents are allowed direct access to Participating Physicians for covered services. Even if you select a Primary Care Physician, there is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Physician of your choice, including Participating Specialist Physicians, for covered services.

Changing Primary Care Physicians

You may request a transfer from one Primary Care Physician to another by visiting our website at www.cigna.com or calling the number on the back of your ID Card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

Direct Access for Mental Health and Substance Use Disorder Services

You are allowed direct access to a licensed/certified Participating Provider for covered Mental Health and Substance Use Disorder Services. There is no requirement to obtain an authorization of care from your Primary Care Physician for individual or group therapy visits to the Participating Provider of your choice for Mental Health and Substance Use Disorder.

PPO Plan Medical Benefits

The Schedule

For You and Your Dependents

PPO Plan Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive PPO Plan 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 Copayment, Deductible or Coinsurance.

When you receive services from an In-Network Provider, remind your provider to utilize In-Network Providers for x-rays, lab tests and other services to ensure the cost may be considered at the In-Network level.

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.

Important Notice on Mental Health and Substance Use Disorder Coverage

Covered medical services received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to the Mental Health and Substance Use Disorder sections of The Schedule.

Coinsurance

The term Coinsurance means the percentage of Covered Expenses that an insured person is required to pay under the plan in addition to the Deductible, if any.

Copayments/Deductibles

Copayments are amounts to be paid by you or your Dependent for covered services. Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this plan. Deductible amounts are separate from and not reduced by Copayments. Copayments and 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.

Carryover Provision

Covered Expenses that were incurred and applied toward any Individual or Family Deductible during the last 3 months of the Calendar Year will be applied toward that next year's deductibles.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%:

- Coinsurance.
- Plan Deductible.

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Non-compliance penalties.
- Any copayments and/or benefit deductibles.
- Provider charges in excess of the Maximum Reimbursable Charge.

PPO Plan Medical Benefits

The Schedule

Accumulation of Plan Out-of-Pocket Maximums

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.

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.

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 Charges for Certain Services

Charges for services furnished by an Out-of-Network provider in an In-Network facility while you are receiving In-Network services at that In-Network facility: (i) are payable at the In-Network cost-sharing level; and (ii) the allowable amount used to determine the Plan's benefit payment is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.
The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made 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.

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 as required by applicable state or Federal law.
3. The allowable amount used to determine the Plan's benefit payment when Out-of-Network Emergency Services result in an inpatient admission is the median amount negotiated with In-Network facilities.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made 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.

PPO Plan Medical Benefits

The Schedule

Out-of-Network Air Ambulance Services Charges

1. Covered air ambulance services are payable 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 air ambulance services rendered by an Out-of-Network provider is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made 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	
The Percentage of Covered Expenses the Plan Pays See Definitions section for an explanation of Maximum Reimbursable Charge.	80%	60%
Calendar Year Deductible		
Individual	Not Applicable	$200 per person
Family Maximum	Not Applicable	$600 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.		
Out-of-Pocket Maximum		
Individual	$1,000 per person	$5,000 per person
Family Maximum	$2,000 per family	$10,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		

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

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office Visit	$20 per visit copay, then 80%	$20 per visit deductible, then 60% coinsurance after plan deductible
Specialty Care Physician's Office Visit	$30 per visit copay, then 80%	$30 per visit deductible, then 60% coinsurance after plan deductible
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 on an In-Network basis. Out-of-Network OB/GYN providers will be considered a Specialist.		
Surgery Performed in the Physician's Office		
Primary Care Physician	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Specialty Care Physician	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Second Opinion Consultations (provided on a voluntary basis)		
Primary Care Physician's Office Visit	$20 per visit copay, then 80%	$20 per visit deductible, then 60% coinsurance after plan deductible
Specialty Care Physician's Office Visit	$30 per visit copay, then 80%	$30 per visit deductible, then 60% coinsurance after plan deductible
Allergy Treatment/Injections		
Primary Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Allergy Serum (dispensed by the Physician in the office)		
Primary Care Physician	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Specialty Care Physician	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Convenience Care Clinic (includes any related lab and x-ray services and surgery)	$20 per visit copay, then 80%	$20 per visit deductible, then 60% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Virtual Care **Dedicated Virtual Providers** Dedicated virtual care services may be provided by MDLIVE, a Cigna affiliate. Services available through contracted virtual providers as medically appropriate. **Notes:** • Primary Care cost share applies to routine care. Virtual wellness screenings are payable under preventive care. • MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below). • Lab services supporting a virtual visit must be obtained through dedicated labs.		
MDLIVE Urgent Care Services	$20 per visit copay, then 80%	In-Network coverage only
MDLIVE Primary Care Services	$20 per visit copay, then 80%	In-Network coverage only
MDLIVE Specialty Care Services	$30 per visit copay, then 80%	In-Network coverage only
Virtual Physician Services Services available through Physicians as medically appropriate. **Note:** Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).		
Primary Care Physician Virtual Office Visit	$20 per visit copay, then 80%	$20 per visit deductible, then 60% coinsurance after plan deductible
Specialty Care Physician Virtual Office Visit	$30 per visit copay, then 80%	$30 per visit deductible, then 60% coinsurance after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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 (for children through age 6)		
Primary Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Routine Preventive Care (for ages 7 and over)		
Primary Care Physician's Office Visit	100% up to a maximum of $750 per Calendar Year; thereafter 80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	100% up to a maximum of $750 per Calendar Year; thereafter 80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Immunizations		
Primary Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Well Woman Exam		
Primary Care Physician's Office Visit	$20 per visit copay, then 80%	$20 per visit deductible, then 60% coinsurance after plan deductible
Specialty Care Physician's Office Visit	$30 per visit copay, then 80%	$30 per visit deductible, then 60% coinsurance after plan deductible
Mammograms		
Preventive Care Related Services (i.e. "routine" services)	100%	Subject to the plan's x-ray benefit & lab benefit; based on place of service
Diagnostic Related Services (i.e. "non-routine" services)	100%	Subject to the plan's x-ray benefit & lab benefit; based on place of service
PSA, PAP Smear		
Preventive Care Related Services (i.e. "routine" services)	Subject to the plan's x-ray benefit & lab benefit; based on place of service	Subject to the plan's x-ray benefit & lab benefit; based on place of service
Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray benefit & lab benefit; based on place of service	Subject to the plan's x-ray benefit & lab benefit; based on place of service

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Early Cancer Detection Colon/Rectal	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Inpatient Hospital – Facility Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services		
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Inpatient Hospital Physician's Visits/Consultations	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Inpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Surgeon		
Radiologist, Pathologist, Anesthesiologist		
Outpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Surgeon		
Radiologist, Pathologist, Anesthesiologist		
Urgent Care Services		
Urgent Care Facility or Outpatient Facility	$20 per visit copay, then 80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the UC visit.		
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the UC visit	$20 per visit copay, then 80%	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency Services		
Hospital Emergency Room Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.	$100 per visit copay (waived if admitted), then 80%	$100 per visit copay (waived if admitted), then 80%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER visit	$100 per visit copay (waived if admitted), then 80%	$100 per visit copay (waived if admitted), then 80%
Air Ambulance	80%	80%
Ambulance	80%	80% of the Maximum Reimbursable Charge
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 100 days combined	80%	Plan deductible, then 80% of the Maximum Reimbursable Charge
Laboratory Services		
Primary Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Hospital Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Independent Lab Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Radiology Services		
Primary Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Hospital Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Primary Care Physician's Office Visit	$20 per visit copay, then 80%	$20 per visit deductible, then 60% coinsurance after plan deductible
Specialty Care Physician's Office Visit	$30 per visit copay, then 80%	$30 per visit deductible, then 60% coinsurance after plan deductible
Inpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Therapy Services		
Calendar Year Maximum: Unlimited		
Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy		
Primary Care Physician's Office Visit	80%	Plan deductible, then 60% coinsurance after plan deductible
Specialty Care Physician's Office Visit	80%	Plan deductible, then 60% coinsurance after plan deductible
Chiropractic Care		
Calendar Year Maximum: 20 days	50%	Plan deductible, then 50% of the Maximum Reimbursable Charge
Acupuncture		
Calendar Year Maximum: $1,000	50%	Plan deductible, then 50% of the Maximum Reimbursable Charge
Orthopedic Shoes		
Lifetime Maximum: $1,500 (includes repairs and maintenance)	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Home Health Care Services		
Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Hospice		
Inpatient Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Services (same coinsurance level as Home Health Care Services)	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Bereavement Counseling Services provided as part of Hospice Care		
Inpatient	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Condition-Specific Care Includes select Medically Necessary preauthorized services, supplies, and/or surgical procedures, subject to program participation requirements. Charges for covered expenses not preauthorized as included in the program are payable subject to applicable copayments, coinsurance, and deductible if any. If you choose to not actively enroll in the program, do not complete the program participation requirements, or utilize a provider who is not designated for the program, charges for covered expenses are payable subject to applicable copayments, coinsurance, and deductible if any.	100%	In-Network coverage only
Condition-Specific Care Travel Maximum $600 per procedure Approved travel amount is variable, up to the travel maximum per procedure, based on factors such as a patient's treatment plan, location and duration of facility stay; and subject to program participation requirements.	100%	Not Applicable

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Medical Pharmaceuticals		
Inpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Cigna Pathwell Specialty Medical Pharmaceuticals	Cigna Pathwell Specialty Network provider: 80% Non-Cigna Pathwell Specialty Network Providers: Not Covered	In-Network coverage only
Other Medical Pharmaceuticals	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary. Gene therapy must be received at an In-Network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other In-Network facilities is not covered.		
Gene Therapy Product	Covered same as Medical Pharmaceuticals	In-Network coverage only
Inpatient Facility	80%	In-Network coverage only
Outpatient Facility	80%	In-Network coverage only
Inpatient Professional Services	80%	In-Network coverage only
Outpatient Professional Services	80%	In-Network coverage only
Advanced Cellular Therapy Includes prior authorized advanced cellular therapy products and related services when Medically Necessary.		
Advanced Cellular Therapy Product	Covered Same as Medical Pharmaceuticals	In-Network coverage only
Inpatient Facility	80%	In-Network coverage only
Outpatient Facility	80%	In-Network coverage only
Inpatient Professional Services	80%	In-Network coverage only
Outpatient Professional Services	80%	In-Network coverage only
Advanced Cellular Therapy Travel Maximum: $10,000 per episode of advanced cellular therapy (Available only for travel when prior authorized to receive advanced cellular therapy from a provider located more than 60 miles of your primary residence and is contracted with Cigna for the specific advanced cellular therapy product and related services.)	100%	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services		
Initial Visit to Confirm Pregnancy		
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna on an In-Network basis. Out-of-Network OB/GYN providers will be considered a Specialist.		
Primary Care Physician's Office Visit	$20 per visit copay, then 80%	$20 per visit deductible, then 60% coinsurance after plan deductible
Specialty Care Physician's Office Visit	$30 per visit copay, then 80%	$30 per visit deductible, then 60% coinsurance after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist		
Primary Care Physician's Office Visit	$20 per visit copay, then 80%	$20 per visit deductible, then 60% coinsurance after plan deductible
Specialty Care Physician's Office Visit	$30 per visit copay, then 80%	$30 per visit deductible, then 60% coinsurance after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Abortion		
Includes only non-elective procedures		
Primary Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Inpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Inpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling		
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.		
Primary Care Physician	$20 per visit copay, then 80%	$20 per visit deductible, then 60% coinsurance after plan deductible
Specialty Care Physician	$30 per visit copay, then 80%	$30 per visit deductible, then 60% coinsurance after plan deductible
Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)		
Primary Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Inpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Inpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Infertility Services 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
Transplant Services and Related Specialty Care Includes all medically appropriate, non-experimental transplants		
Primary Care Physician's Office Visit	$20 per visit copay, then 80%	$20 per visit deductible, then 60% coinsurance after plan deductible
Specialty Care Physician's Office Visit	$30 per visit copay, then 80%	$30 per visit deductible, then 60% coinsurance after plan deductible
Inpatient Facility	100% at LifeSOURCE center, otherwise 80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Inpatient Professional Services	100% at LifeSOURCE center, otherwise 80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Travel Maximum: $10,000 per transplant	100% (only available when using LifeSOURCE facility)	In-Network coverage only
Durable Medical Equipment Calendar Year Maximum: Unlimited	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Dialysis Services		
Primary Care Physician's Office Visit	$20 per visit copay, then 80%	$20 per visit deductible, then 60% coinsurance after plan deductible
Specialty Care Physician's Office Visit	$30 per visit copay, then 80%	$30 per visit deductible, then 60% coinsurance after plan deductible
Outpatient Facility Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Home Setting	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
External Prosthetic Appliances Calendar Year Maximum: Unlimited	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Nutritional Counseling 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.		
Primary Care Physician's Office Visit	$20 per visit copay, then 80%	$20 per visit deductible, then 60% coinsurance after plan deductible
Specialty Care Physician's Office Visit	$30 per visit copay, then 80%	$30 per visit deductible, then 60% coinsurance after plan deductible
Inpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Inpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Genetic Counseling Calendar Year Maximum: 3 visits per person for Genetic Counseling for both pre- and post-genetic testing; however, the 3 visit limit will not apply to Mental Health and Substance Use Disorder conditions.		
Primary Care Physician's Office Visit	$20 per visit copay, then 80%	$20 per visit deductible, then 60% coinsurance after plan deductible
Specialty Care Physician's Office Visit	$30 per visit copay, then 80%	$30 per visit deductible, then 60% coinsurance after plan deductible
Inpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Inpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Dental Care Limited to charges made for a continuous course of dental treatment for an Injury to teeth.		
Primary Care Physician's Office Visit	$20 per visit copay, then 80%	$20 per visit deductible, then 60% coinsurance after plan deductible
Specialty Care Physician's Office Visit	$30 per visit copay, then 80%	$30 per visit deductible, then 60% coinsurance after plan deductible
Inpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Inpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
TMJ Surgical		
Always excludes orthodontic treatment.		
Primary Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Inpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Facility	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Inpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient Professional Services	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
TMJ Non-Surgical		
Primary Care Physician's Office Visit	50%	Plan deductible, then 50% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	50%	Plan deductible, then 50% of the Maximum Reimbursable Charge
Inpatient Facility	50%	Plan deductible, then 50% of the Maximum Reimbursable Charge
Outpatient Facility	50%	Plan deductible, then 50% of the Maximum Reimbursable Charge
Inpatient Professional Services	50%	Plan deductible, then 50% of the Maximum Reimbursable Charge
Outpatient Professional Services	50%	Plan deductible, then 50% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Bariatric Surgery **Note:** Subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate.		
Primary Care Physician's Office Visit	80%	In-Network coverage only
Specialty Care Physician's Office Visit	80%	In-Network coverage only
Inpatient Facility	80%	In-Network coverage only
Outpatient Facility	80%	In-Network coverage only
Inpatient Professional Services	80%	In-Network coverage only
Outpatient Professional Services	80%	In-Network coverage only
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes, peripheral neuropathies 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.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health		
Inpatient Includes Acute Inpatient and Residential Treatment Calendar Year Maximum: Unlimited	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient		
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited	$20 per visit copay, then 80%	$20 per visit deductible, then plan deductible, then 60% of the Maximum Reimbursable Charge
Dedicated Virtual Providers MDLIVE Behavioral Services	$20 per visit copay, then 80%	In-Network coverage only
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc. Calendar Year Maximum: Unlimited	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Substance Use Disorder		
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Calendar Year Maximum: Unlimited	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge
Outpatient		
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited	$20 per visit copay, then 80%	$20 per visit deductible, then plan deductible, then 60% of the Maximum Reimbursable Charge
Dedicated Virtual Providers MDLIVE Behavioral Services	$20 per visit copay, then 80%	In-Network coverage only
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc. Calendar Year Maximum: Unlimited	80%	Plan deductible, then 60% of the Maximum Reimbursable Charge

PPO Plan Medical Benefits

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/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 require treatment in a Hospital:

- as a registered bed patient, except for 48/96 hour maternity stays;
- for Mental Health or Substance Use Disorder 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 for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- Hospital charges for Room 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.

Outpatient Certification Requirements – Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-Standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should only be requested for non-emergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

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.

Outpatient Procedures

Including, but not limited to:

- Medical Pharmaceuticals.

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Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating 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.
- non-emergency Ambulance.
- certain Medical Pharmaceuticals.

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Covered Expenses

The term Covered Expenses means expenses incurred by a person while covered under this plan for the charges listed below for:

- preventive care services; and

- services or supplies that are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna.

As determined by Cigna, Covered Expenses may also include all charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- charges for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital, subject to the limits as shown in The Schedule.
- charges for inpatient Room and Board and other Necessary Services and Supplies made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility as shown in The Schedule.
- charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
- charges for outpatient medical care and treatment received at a Hospital.
- charges for outpatient medical care and treatment received at a Free-Standing Surgical Facility.
- charges for Emergency Services.
- charges for Urgent Care.
- charges by a Physician or a Psychologist for professional services.
- charges by a Nurse for professional nursing service.
- charges for anesthetics, including, but not limited to supplies and their administration.
- charges for diagnostic x-ray.
- charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.
- charges for chemotherapy.
- charges for blood transfusions.
- charges for oxygen and other gases and their administration.
- charges for Medically Necessary foot care for diabetes, peripheral neuropathies, and peripheral vascular disease.
- charges for screening prostate-specific antigen (PSA) testing.
- charges 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, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges for abortion when a Physician certifies in writing that the pregnancy would endanger the life of the mother, or when the expenses are incurred to treat medical complications due to abortion.
- charges for the following preventive care services as defined by recommendations from the following:
  - the U.S. Preventive Services Task Force (A and B recommendations);
  - the Advisory Committee on Immunization Practices (ACIP) for immunizations;
  - the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;
  - the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
  - with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.

  Detailed information is available at www.healthcare.gov. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.
- charges for medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered for an established medical condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Penile implants are not covered as treatment of psychogenic erectile dysfunction.
- charges for surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- charges for acupuncture.
- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.
- charges for 1) a single baseline mammogram for women ages 35 to 40; 2) mammograms every two years for women age 40 to 50 or more often if prescribed by a Physician; and 3) annual mammograms for women age 50 or older.
- charges for hearing aids for children under 18 years of age. This applies to children who are Dependents under the policy and also to individuals under 18 years of age who are

policyholders. The coverage must be for one hearing aid per individual hearing aid per ear, every 3 years and includes services necessary to select, fit and adjust the hearing aid. Batteries, cords and other assistive devices such as FM systems will not be covered.

- charges for treatment of conditions or disorders of hearing, speech, voice or language if treatment is received from a licensed audiologist or speech pathologist.

Virtual Care Dedicated Virtual Providers

Includes charges for the delivery of real-time medical and health-related services, consultations and remote monitoring by dedicated virtual providers as medically appropriate through audio, video and secure internet-based technologies.

Includes charges for the delivery of mental health and substance use disorder-related services, consultations, and remote monitoring by dedicated virtual providers as appropriate through audio, video and secure internet-based technologies.

Virtual Physician Services

Includes charges for the delivery of real-time medical and health-related services, consultations and remote monitoring as medically appropriate through audio, video and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.

Includes charges for the delivery of real-time mental health and substance use disorder consultations and services, via secure telecommunications technologies that shall include video capability, telephone and internet, when such consultations and services are delivered by a behavioral provider and are similar to office visit services provided in a face-to-face setting.

Convenience Care Clinic

Convenience Care Clinics provide for common ailments and routine services, including but not limited to, strep throat, ear infections or pink eye, immunizations and flu shots.

Nutritional Counseling

Charges for nutritional counseling when diet is a part of the medical management of a medical or behavioral condition.

Enteral Nutrition

Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism (e.g., disorders of amino acid or organic acid metabolism).

Internal Prosthetic/Medical Appliances

Charges for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

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Home Health Care Services

Charges for skilled care provided by certain health care providers during a visit to the home, when the home is determined to be a medically appropriate setting for the services. A visit is defined as a period of 2 hours or less. Home Health Care Services are subject to a maximum of 16 hours in total per day.

Home Health Care Services are covered when skilled care is required under any of the following conditions:

- the required skilled care cannot be obtained in an outpatient facility.
- confinement in a Hospital or Other Health Care Facility is not required.
- the patient's home is determined by Cigna to be the most medically appropriate place to receive specific services.

Covered services include:

- skilled nursing services provided by a Registered Nurse (RN), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse (APRN).
- services provided by health care providers such as physical therapist, occupational therapist and speech therapist.
- services of a home health aide when provided in direct support of those nurses and health care providers.
- necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.

Note: Physical, occupational, and other Outpatient Therapy Services provided in the home are covered under the Outpatient Therapy Services benefit shown in The Schedule.

The following are excluded from coverage:

- services provided by a person who is a member of the patient's family, even when that person is a health care provider.
- services provided by a person who normally resides in the patient's house, even when that person is a health care provider.
- non-skilled care, Custodial Services, and assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other services; self-care activities; homemaker services; and services primarily for rest, domiciliary or convalescent care.

Home Health Care Services, for a patient who is dependent upon others for non-skilled care and/or Custodial Services, is provided only when there is a family member or caregiver present in the home at the time of the health care visit to provide the non-skilled care and/or Custodial Services.

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Condition-Specific Care

The Condition-Specific Care benefit supports programs that are designed to help guide your care and may reduce your out-of-pocket costs related to select Medically Necessary preauthorized services, supplies, and/or surgical procedures.

Contact Cigna at the phone number on your ID card for information about the programs available under the Condition-Specific Care benefit. For the program you are interested in, a list of services, supplies, and/or surgical procedures included under the program will be provided to you.

In order to be eligible for Condition-Specific Care benefits, you must enroll in an available program prior to receiving services, supplies, and/or surgical procedure(s) covered under the program; fulfill your responsibilities under the program; receive your care from a designated provider for the program; and this plan must be your primary medical plan for coordination of benefits purposes. To enroll in the program, contact Cigna at the phone number on your ID card.

If all requirements are met, and subject to plan terms and conditions, the preauthorized services, supplies, and/or surgical procedure(s) will be payable under the plan as shown in the Condition-Specific Care benefit in The Schedule.

Charges for covered expenses not included in the preauthorized services, supplies, and/or surgical procedure(s) are payable subject to applicable Copayments, Coinsurance, and Deductible if any.

If you choose to not actively enroll in the program, do not complete the program participation requirements, or utilize a provider who is not designated for the program, charges for covered expenses are payable subject to applicable Copayments, Coinsurance, and Deductible if any.

Condition-Specific Care Travel Services

Charges made for non-taxable travel expenses for transportation and lodging, incurred by you in connection with a preapproved procedure or service under the program are covered subject to the following conditions and limitations:

- You are the recipient of a preapproved procedure or service under the program.
- The service and/or procedure is received from a designated provider for the program.
- You need to travel more than a 60-mile radius from your primary residence.

The term recipient is defined to include a person receiving authorized procedures or services under the program. The travel benefit is designed to offset the recipient's travel expenses, including charges for: transportation to and from the procedure or service site; and lodging while at, or traveling to and from the procedure or service site.

In addition, the travel benefit is designed to offset travel expenses for charges associated with the items above 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 expenses that if reimbursed would be taxable income, travel costs incurred due to travel within a 60 mile radius of your home, depending on the procedure being performed; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

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Hospice Care Services

Charges for services for a person diagnosed with advanced illness having a life expectancy of twelve or fewer months. Services provided by a Hospice Care Program are available to those who have ceased treatment and to those continuing to receive curative treatment and therapies.

Hospice Care Programs rendered by Hospice Facilities or Hospitals include services:

- by a Hospice Facility for Room 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, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies;

Hospice Care Programs rendered by Other Health Care Facilities or in the Home include services:

- for part-time or intermittent nursing care by or under the supervision of a Nurse;
- for part-time or intermittent services of an Other Health Professional;
- physical, occupational and speech therapy;

- medical supplies;
- drugs and medicines lawfully dispensed only on the written prescription of a Physician;
- 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:

- 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;
- services for any period when you or your Dependent is not under the care of a Physician;
- services or supplies not listed in the Hospice Care Program;
- to the extent that any other benefits are payable for those expenses under the policy;
- services or supplies that are primarily to aid you or your Dependent in daily living.

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Mental Health and Substance Use Disorder Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes.

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent are 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 are 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 are 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 are 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:

- 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.

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.

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
- ventilators
- wheelchairs
- insulin pumps
- incontinence supplies when the member is totally incontinent and the incontinence is the result of an injury to the spinal cord or brain trauma
- talking glucose monitors for visually impaired or intellectually disabled members
- thermal insulin carrying cases/devices, limited to two cases/devices per calendar year
- the rental of breastfeeding equipment and supplies as ordered or prescribed by a physician.

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.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers and air purifiers.
- **Other Equipment:** centrifuges, needleless injectors, heat lamps, heating pads, cryounits, cryotherapy machines, ultraviolet cabinets, that emit Ultraviolet A (UVA) rays sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, 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.

External prosthetic appliances and devices 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:

- limb prostheses;
- terminal devices such as hands or hooks;
- speech prostheses; and
- facial 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:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid 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;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- non-foot orthoses primarily used for cosmetic rather than functional reasons; and
- non-foot 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 required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- replacement due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited as follows:

- no more than once every 24 months for persons 19 years of age and older.
- no more than once every 12 months for persons 18 years of age and under.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements for external prosthetic devices; or
- microprocessor controlled prostheses and orthoses; and• myoelectric prostheses and orthoses.

Outpatient Therapy Services

Charges for the following therapy services:

Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy

- Charges for therapy services are covered when provided as part of a program of treatment.

Cardiac Rehabilitation

- Charges for 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.

Chiropractic Care Services

- Charges 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.

Coverage is provided when Medically Necessary in the most medically appropriate setting to:

- Restore function (called "rehabilitative"):
  - To restore function that has been impaired or lost.
  - To reduce pain as a result of Sickness, Injury, or loss of a body part.
- Improve, adapt or attain function (sometimes called "habilitative"):
  - To improve, adapt or attain function that has been impaired or was never achieved as a result of congenital abnormality (birth defect).
  - To improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions. Includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.

Coverage is provided as part of a program of treatment when the following criteria are met:

- The individual's condition has the potential to improve or is improving in response to therapy, and maximum improvement is yet to be attained.
- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The therapy is provided by, or under the direct supervision of, a licensed health care professional acting within the scope of the license.
- The therapy is Medically Necessary and medically appropriate for the diagnosed condition.

Coverage for occupational therapy is provided only for purposes of enabling individuals to perform the activities of daily living after an Injury or Sickness.

Therapy services that are not covered include:

- sensory integration therapy.
- treatment of dyslexia.
- maintenance or preventive treatment provided to prevent recurrence or to maintain the patient's current status.
- charges for Chiropractic Care not provided in an office setting.
- vitamin therapy.

Coverage is administered according to the following:

- Multiple therapy services provided on the same day constitute one day of service for each therapy type.

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and prosthetics, limited to the lowest cost alternative available that meets 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: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or 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.

HC-COV631 12-17

Transplant Services and Related Specialty Care

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. Implantation procedures are also covered for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO) ventricular assist device (VAD) and intra-aortic balloon pump (IABP) are also covered.

- All transplant services and related specialty care services, other than cornea transplants, are covered when received at Cigna LifeSOURCE Transplant Network® facilities.
- Transplant services and related specialty care services received at Participating Provider facilities specifically contracted with Cigna for those transplant services and related specialty care services, other than Cigna LifeSOURCE Transplant Network® facilities, are payable at the In-Network level.
- Transplant services and related specialty care services received at any other facility, including non-Participating Provider facilities and Participating Provider facilities not specifically contracted with Cigna for transplant services and related specialty care services, are covered at the Out-of-Network level.
- Cornea transplants received at a facility that is specifically contracted with Cigna for this type of transplant are payable at the In-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 hospitalization and surgery necessary for removal of an organ and transportation of a live donor (refer to Transplant and Related Specialty Care Travel Services). 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 and Related Specialty Care 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 and related specialty care travel benefits are not available for cornea transplants.
- Benefits for transportation and lodging are available to the recipient of a preapproved organ/tissue transplant and/or related specialty care 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 designated Cigna LifeSOURCE Transplant Network® facility (including charges for a rental car used during a period of care at the designated Cigna LifeSOURCE Transplant Network® facility); and lodging while at, or traveling to and from, the designated Cigna LifeSOURCE Transplant Network® facility.
- 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 expenses 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 for Transplant Services and Related Specialty Care, and for Transplant and Related Specialty Care Travel Services 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 transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant, the transplant recipient's plan would cover all donor costs.

HC-COV1328 04-23

Advanced Cellular Therapy

Charges for advanced cellular therapy products and services directly related to their administration are covered when Medically Necessary. Coverage includes the cost of the advanced cellular therapy product; medical, surgical, and facility services directly related to administration of the advanced cellular therapy product, and professional services.

Cigna determines which U.S. Food and Drug Administration (FDA) approved products are in the category of advanced cellular therapy, based on the nature of the treatment and how it is manufactured, distributed and administered. An example of advanced cellular therapy is chimeric antigen receptor (CAR) T-cell therapy that redirects a person's T cells to recognize and kill a specific type of cancer cell.

Advanced cellular therapy products and their administration are covered at the In-Network benefit level when prior authorized to be received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services. Advanced cellular therapy products and their administration received from a provider that is not contracted with Cigna for the specific advanced cellular therapy product and related services are not covered.

Advanced Cellular Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized advanced cellular therapy product are covered, subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when:

- you are the recipient of a prior authorized advanced cellular therapy product;
- the term recipient is defined to include a person receiving prior authorized advanced cellular therapy related services during any of the following: evaluation, candidacy, event, or post care;
- the advanced cellular therapy products and services directly related to their administration are received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services; and
- the provider is not available within a 60 mile radius of your primary home residence.

Travel expenses for the person receiving the advanced cellular therapy include charges for: transportation to and from the advanced cellular therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the 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 expenses that if reimbursed would be taxable income, travel costs incurred due to travel within a 60 mile radius of your primary home residence; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

HC-COV1327 04-23

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that may be administered in an Inpatient setting, Outpatient setting, Physician's office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals that, because of their characteristics as determined by Cigna, require a qualified licensed health care professional to administer or directly supervise administration.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive coverage, the covered person may be required to try a specific Medical Pharmaceutical before trying others. Medical Pharmaceuticals administered in an Inpatient facility are reviewed per Inpatient review guidelines.

Cigna determines the utilization management requirements and other coverage conditions that apply to a Medical Pharmaceutical by considering a number of factors:

- Clinical factors, which may include Cigna's evaluations of the site of care and the relative safety or relative efficacy of Medical Pharmaceuticals.
- Economic factors, which may include the cost of the Medical Pharmaceutical and assessments of cost effectiveness after rebates.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include an increase in the cost of a Medical Pharmaceutical.

Certain Medical Pharmaceuticals that are used for treatment of complex chronic conditions, are high cost, and are administered and handled in a specialized manner may be subject to additional coverage criteria or require administration by a participating provider in the network for the Cigna Pathwell Specialty Network. Cigna determines which injections, infusions, and implantable drugs are subject to these criteria and requirements.

The Cigna Pathwell Specialty Network includes contracted physician offices, ambulatory infusion centers, home and outpatient hospital infusion centers, and contracted specialty pharmacies. When the Cigna Pathwell Specialty Network cannot meet the clinical needs of the customer as determined by Cigna, exceptions are considered and approved when appropriate.

A complete list of those Medical Pharmaceuticals subject to additional coverage criteria or that require administration by a participating provider in the Cigna Pathwell Specialty Network is available at www.cigna.com/PathwellSpecialty.

The following are not covered under the plan:

- Medical Pharmaceutical regimens that have a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s);
- Medical Pharmaceuticals newly approved by the Food & Drug Administration (FDA) up to the first 180 days following its market launch;
- Medical Pharmaceutical regimens for which there is an appropriate lower cost alternative for treatment.

In the event a covered Medical Pharmaceutical is not clinically appropriate, Cigna makes available an exception process to allow for access to non-covered drugs when Medically Necessary.

Cigna may consider certain Medical Pharmaceutical regimens as preferred when they are clinically effective treatments and the most cost effective. Preferred regimens are covered unless the covered person is not a candidate for the regimen and a Medical Necessity coverage exception is obtained.

HC-COV1186 04-23
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Gene Therapy

Charges for gene therapy products and services directly related to their administration are covered when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when prior authorized to be received at In-Network facilities specifically contracted with Cigna for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered.

HC-COV873 M 01-20

Clinical Trials

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate; or
- the individual provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered.

The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that meets **any** of the following criteria:

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH).
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Health Care Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).
  - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
  - any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:
    - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and

  - the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The plan does not cover any of the following services associated with a clinical trial:

- services that are not considered routine patient care costs and services, including the following:
  - the investigational drug, device, item, or service that is provided solely to satisfy data collection and analysis needs.
  - an item or service that is not used in the direct clinical management of the individual.
  - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- an item or service provided by the research sponsors free of charge for any person enrolled in the trial.
- travel and transportation expenses, unless otherwise covered under the plan, including but not limited to the following:
  - fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train.
  - mileage reimbursement for driving a personal vehicle.
  - lodging.
  - meals.
- routine patient costs obtained out-of-network when Out-of- Network benefits do not exist under the plan.

Examples of routine patient care costs and services include:

- radiological services.
- laboratory services.
- intravenous therapy.
- anesthesia services.
- Physician services.
- office services.
- Hospital services.
- Room and Board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

Clinical trials conducted by Out-of-Network providers will be covered only when the following conditions are met:

- In-Network providers are not participating in the clinical trial; or
- the clinical trial is conducted outside the individual's state of residence.

HC-COV1128 01-22

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.

You and your Dependents will pay 100% of the cost of any Prescription Drug Product excluded from coverage under this plan. The amount you and your Dependent pays for any excluded Prescription Drug Product to the dispensing Pharmacy, will not count towards your Deductible, if any, or Out-of-Pocket Maximum.

Copayments (Copay)

Copayments are amounts to be paid by you or your Dependent for covered Prescription Drug Products.

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	OUT -OF-NETWORK PHARMACY
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	OUT-OF-NETWORK PHARMACY
Patient Assurance Program Your plan offers additional discounts for certain covered Prescription Drug Products that are dispensed by a retail or home delivery Network Pharmacy included in what is known as the "Patient Assurance Program". As may be described elsewhere in this plan, from time to time Cigna may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your Out-of-Pocket Expenses for certain covered Prescription Drug Products for which Cigna directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna for certain covered Prescription Drug Products included in the Patient Assurance Program is applied or credited to a portion of your Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drug Products as set forth in The Schedule may be reduced in order for Patient Assurance Program discounts earned by Cigna to be applied or credited to the Copayment or Coinsurance, if any, as described above. For example, certain insulin product(s) covered under the Prescription Drug Benefit for which Cigna directly or indirectly earns a discount in connection with the Patient Assurance Program shall result in a credit toward some or all of your Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in The Schedule, for the insulin product. In addition, the covered insulin products eligible for Patient Assurance Program discounts shall not be subject to the Deductible, if any. Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum. Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum. Please note that the Patient Assurance Program discounts that Cigna may earn for Prescription Drug Products, and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any rebates or other payments that Cigna may earn from a pharmaceutical manufacturer for the same or other Prescription Drug Products. Except as may be noted elsewhere in this plan, you are not entitled to the benefit of those rebates or other payments earned by Cigna because they are unrelated to the Patient Assurance Program. Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drug Products included in the Patient Assurance Program and/or your Copayment or Coinsurance, if any for those eligible Prescription Drug Products, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to Cigna in connection with the Patient Assurance Program. More information about the Patient Assurance Program including the Prescription Drug Products included in the program, is available at the website shown on your ID card or by calling member services at the telephone number on your ID card.		
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 102 day supply per Prescription Order or Refill at a retail Designated Pharmacy or home delivery Network Pharmacy.		

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	OUT-OF-NETWORK PHARMACY
Certain Preventive 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 34-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 34-day supply at a non-Network Pharmacy**
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $10 Copay	No charge after $10 Copay
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $30 Copay	No charge after $30 Copay
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $30 Copay	No charge after $30 Copay
Prescription Drug Products at Retail Designated Pharmacies	**The amount you pay for up to a consecutive 102-day supply at a Designated Pharmacy**	**The amount you pay for up to a consecutive 102-day supply at a non- Designated Pharmacy**
Specialty Prescription Drug Products are limited to up to a consecutive 34-day supply per Prescription Order or Refill.		
Note: In this context, a retail Designated Pharmacy is a retail Network Pharmacy that has contracted with Cigna for dispensing of covered Prescription Drug Products, including Maintenance Drug Products, in 102-day supplies per Prescription Order or Refill.		
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $20 Copay	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $60 Copay	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $60 Copay	In-network coverage only

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	OUT-OF-NETWORK PHARMACY
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 102-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 102-day supply at a non- Network Pharmacy**
Specialty Prescription Drug Products are limited to up to a consecutive 34-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	No charge after $20 Copay	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $60 Copay	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $60 Copay	In-network coverage only

Prescription Drug Benefits

Covered Expenses

Your plan provides benefits for Prescription Drug Products on the Prescription Drug List that are dispensed by a Pharmacy. Details regarding your plan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations, and Exclusions are provided below and/or 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, your plan provides 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 pursuant to the, as applicable, Copayment or Coinsurance for the Prescription Drug Product when dispensed by a Network Pharmacy.

Prescription Drug List Management

Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. Determination of inclusion of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and utilization management requirements or other coverage conditions are based on a number of factors which may include, 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. 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 Prescription Drug List 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.

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Limitations

Your plan includes a Brand Drug for Generic Drug dispensing program. This program allows certain Brand Drugs to be dispensed in place of the Therapeutic Equivalent Generic Drug at the time your Prescription Order or Refill is processed by a participating Pharmacy. Brand Drug for Generic Drug substitution will occur only for certain Brand Drugs included in the program. When this substitution program is applied, the participating Pharmacy will dispense the Brand Drug to you in place of the available Generic Drug. You will be responsible for payment of only a Generic Drug Copayment and/or Coinsurance, after satisfying your Deductible, if any.

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, Cigna may direct you to a Designated Pharmacy with whom Cigna has 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

New Prescription Drug Products may or may not be placed on a Prescription Drug List tier upon market entry. Cigna will use reasonable efforts to make a tier placement decision for a New Prescription Drug Product within six months of its market availability. Cigna'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.

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Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule, as well as any

limitations or exclusions set forth in this plan. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

Copayment

Your plan requires that you pay a Copayment for covered Prescription Drug Products as set forth in The Schedule. After satisfying any applicable annual Deductible set forth in The Schedule, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy and that is subject to a Copayment requirement will be the lowest of the following amounts:

- the Copayment for the Prescription Drug Product set forth in The Schedule; or
- the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

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.

You will need to obtain prior approval from Cigna or its Review Organization for any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded. If Cigna or its Review Organization approves coverage for the Prescription Drug Product because it meets the applicable coverage exception criteria, the Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

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 Prescription Drug List 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 or anti-aging purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth 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.

- medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions unless specifically identified on the Prescription Drug List.
- 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.

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Reimbursement/Filing a Claim

Retail Pharmacy

When you or your Dependents purchase your Prescription Drug Products through a 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 for a Prescription Drug Product obtained at a Network Pharmacy unless you pay the full cost of a Prescription Drug Product at a Network Pharmacy and later seek reimbursement for the Prescription Drug Product under the plan. For example, if you must pay the full cost of a Prescription Drug Product to the retail Network Pharmacy because you did not have your ID card, then you must submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. If, under this example, your payment to the retail Network Pharmacy for the covered Prescription Drug Product exceeds any applicable copay, then you will be reimbursed the difference, if any, between the applicable copay and the Prescription Drug Charge for the Prescription Drug Product.

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- charges which you are not obligated to pay and/or for which you are not billed. This exclusion includes, but is not limited to:
  - any instance where Cigna determines that a provider or Pharmacy did not bill you for or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.
  - charges of a non-Participating Provider who has agreed to charge you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.

  In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:
  - require you and/or any provider or Pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna;
  - deny the payment of benefits in connection with the Covered Expense regardless of whether the provider or the Pharmacy represents that you remain responsible for any amounts that your plan does not cover; or
  - reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover.
- charges or payment for healthcare-related services that violate state or federal law.

- 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 use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - 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;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- the following services are excluded from coverage regardless of clinical indications: acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for a continuous course of dental treatment for an Injury to teeth are covered. Additionally, charges made by a Physician for any of the following Surgical Procedures are covered: excision of unerupted impacted wisdom tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth).
- 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.
- 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, unless otherwise covered under this plan.
- court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under 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 is also excluded from coverage.
- reversal of male and female voluntary sterilization procedures.
- for treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction, anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under this plan.

- for non-medical ancillary services, including but not limited to vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities, developmental delays, autism or intellectual disabilities.
- 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 Care 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 Care 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 arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, for individuals who are 18 years of age or older, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames, contact lenses and associated services (exams and fittings) (except for the initial set after treatment of keratoconus or following cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- all non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.
- membership costs and fees associated with health clubs, weight loss programs or 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.
- dental implants for any condition.
- fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines 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 medications for the purpose of travel, or to protect against occupational hazards and risks.
- health and beauty aids, cosmetics and dietary supplements.
- all nutritional supplements, formulae, enteral feedings, supplies and specially formulated medical foods, whether prescribed or not except for infant formula needed for the treatment of inborn errors of metabolism.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges related to an Injury or Sickness payable under worker's compensation or similar laws.
- massage therapy.
- products and supplies associated with the administration of medications that are available to be covered under the Prescription Drug Benefit. Such products and supplies include but are not limited to therapeutic Continuous Glucose Monitor (CGM) sensors and transmitters and insulin pods.
- abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.
- expenses incurred by a participant to the extent reimbursable under automobile insurance coverage. Coverage under this plan is secondary to automobile no-fault insurance or similar coverage. The coverage provided

under this plan does not constitute "Qualified Health Coverage" under Michigan law and therefore does not replace Personal Injury Protection (PIP) coverage provided under an automobile insurance policy issued to a Michigan resident. This plan will cover expenses only not otherwise covered by the PIP coverage.

- gender reassignment surgery.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- for charges 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 any charges related to care provided through a public program, other than Medicaid.
- for charges which would not have been made if the person did not have coverage.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- for expenses for services, supplies, care, treatment, drugs or surgery that are not Medically Necessary.
- for charges made by any Physician or Other Health Professional who is a member of your family or your Dependent's family.
- for expenses incurred outside the United States other than expenses for Medically Necessary emergency or urgent care while temporarily traveling abroad.

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

The amount of charges considered for payment under the Plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an Employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or Employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child; and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active Employee (or as that Employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired Employee (or as that Employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active Employee or retiree (or as that Employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans are not more than 100% of the total of all Allowable Expenses.

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which Cigna is obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare Plan or other organization. If Cigna requests, you must execute and deliver to us such instruments and documents as Cigna determines are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information Cigna requests in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 55 days of the request, the claim will be closed. If the requested information is subsequently received, the claim will be processed.

Requirement to Enroll in Medicare When Eligible

Metro requires all pensioners and dependents to enroll in Medicare Parts A & B when you first become eligible regardless of your employment or your spouse's employment status outside of Metro. If a pensioner or a dependent does not enroll in Medicare Parts A & B when they become eligible, they are no longer eligible for Metro medical insurance. When the pensioner and his/her covered dependents are all eligible for Medicare, they will no longer be eligible for Metro's medical insurance unless they are all enrolled in Medicare Parts A & B.

Once a pensioner and all dependents turn age 65 and become eligible for Medicare, then they are no longer eligible to be enrolled in Metro's PPO plan because their **only** medical plan option is Metro's Medicare Advantage Plan. To be in Metro's Medicare Advantage Plan, a person must be enrolled in Medicare Parts A & B; therefore, it is imperative to apply for Medicare Parts A & B 3 months in advance of turning age 65. If you do not have Medicare Parts A & B when you turn age 65, you and your dependents will no longer be eligible for any Metro medical insurance.

If you retire from Metro on or after age 65, you must also apply for Medicare Part B so that it is effective by the same date your Metro retiree medical insurance is effective. This is important because a Metro retiree who is age 65 or older is only eligible for Metro's Medicare Advantage Plans, and to be in Metro's Medicare Advantage Plans, you must be enrolled in Medicare Parts A and B. Therefore, if you do not have Medicare Part B by the same date your retiree medical insurance is effective, you will no longer be eligible for any Metro medical insurance.

Coordination of Benefits with Medicare

Pensioners and their Dependents are required to elect Part B when it is first offered regardless of employment status. Medicare coordination 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. In-Network claims will be applied to the In-Network Out-of-Pocket Maximum; Out-of-Network claims will be applied to the Out-of-Network Out-of-Pocket Maximum. This provision applies for Members who retired from Metro after October 1, 1993. For single coverage, a Pensioner who is eligible for Medicare is not an eligible participant in this Plan unless otherwise required by law. For family coverage, the Pensioner and Dependents will no longer be eligible participants in this Plan when the Pensioner and all covered Dependents become eligible for Medicare, unless otherwise required by law.

If you, your spouse, or your Dependent are covered under this Plan and qualify for Medicare, federal law determines which Plan is the primary payer and which is the secondary payer. The primary payer always determines covered benefits first, without considering what any other coverage will pay. The secondary payer determines its coverage only after the Primary Plan has completed its determination.

When Medicare is the Primary Payer

Medicare will be the primary payer and this Plan will be the secondary payer, even if you don't elect to enroll in Medicare or you receive services from a provider who does not accept Medicare payments, in the following situations:

- COBRA or State Continuation: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to COBRA or state continuation of coverage.
- Retirement or Termination of Employment: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to your retirement or termination of employment.
- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has fewer than 100 employees.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has fewer than 20 employees.

- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan will be the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

When This Plan is the Primary Payer

This Plan will be the primary payer and Medicare will be the secondary payer in the following situations:

- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has 100 or more employees.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has 20 or more employees.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan is the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

Domestic Partners

Under federal law, when Medicare coverage is due to age, Medicare is always the primary payer and this Plan is the secondary payer for a person covered under this Plan as a Domestic Partner. However, when Medicare coverage is due to disability, the Disability payer explanations above will apply.

Assistance with Medicare Questions

For more information on Medicare's rules and regulations, contact Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. You may also contact the Social Security Administration toll-free at 1-800-772-1213, at www.ssa.gov, or call your local Social Security Administration office.

HC-COB273 01-21

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault insurance or similar coverage.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written

consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.

- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

HC-SUB128 03-20

Payment of Benefits

Assignment and Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

You may, however, authorize Cigna to pay any healthcare benefits under this policy to a Participating or Non- Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or Non-Participating

Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Expenses directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or Non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a Non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the Non-Participating 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.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

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.

Termination, Reinstatement And Continuation 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 Pensioner and all covered Dependents become Medicare eligible, unless otherwise required by law;
- 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 of 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 preceding the date the last member's Medicare becomes effective;
- The end of the month of 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 of 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 of 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 of 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 of 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 in accordance with the Board's policy on insurance arrears and refunds.

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.

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 Metro's 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 21). 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.

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 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 may only add eligible Dependents within 60 days of an eligible change in status event.

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.

Medical Benefits Extension During Hospital Confinement

If the Medical Benefits under this plan cease for you or your Dependent, and you or your Dependent is Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group plan;
- the date you or your Dependent is no longer Hospital Confined; or
- 3 months from the date your Medical Benefits cease.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when your Medical Benefits cease or your Dependent's Medical Benefits cease.

HC-BEX44 01-13

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

HC-FED1 10-10

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

Notice Regarding Pharmacy Directories and Pharmacy Networks

A list of network pharmacies is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of pharmacies affiliated or contracted with Cigna or an organization contracting on its behalf.

HC-FED78 10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 60 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

HC-FED4 10-10

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed:

- if you meet Special Enrollment criteria and enroll as described in the Special Enrollment section; or
- if your Employer agrees, and you meet the criteria shown in the following Sections B through H and enroll for or change coverage within the time period established by your Employer.

B. Change of status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid eligibility/entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in cost of coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in coverage of spouse or Dependent under another employer's plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

G. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in a Qualified Health Plan (QHP)

Employee: The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through an Exchange (Marketplace) or the Employee seeks to enroll in a QHP through an Exchange during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through an Exchange for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

Family: A plan may allow an Employee to revoke family coverage midyear in order for family members ("related individuals") to enroll in a QHP through an Exchange (Marketplace). The related individual(s) must be eligible for a Special Enrollment Period to enroll in a QHP or seek to enroll in a QHP during the Marketplace's annual open enrollment period, and the disenrollment from the group plan corresponds to the intended enrollment of the individual(s) in a QHP for new coverage effective beginning no later than the day immediately following the last day of the original coverage. If the Employee does not enroll in a QHP, the Employee must select self-only coverage or family coverage including one or more already-covered individuals.

HC-FED112 01-23

Coverage for Maternity Hospital Stay

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

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

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

HC-FED10 10-10

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.

HC-FED12 10-10

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13 10-10

Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer. 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 be held in arrears and will be collected when you return to work.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

HC-FED93 10-17

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

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.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

HC-FED18 10-10

Claim Determination Procedures

The following complies with federal law. Provisions of applicable laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. The booklet describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described below, in the booklet, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the booklet, in your provider's network participation documents as applicable, and in the determination notices.

Note: An oral statement made to you by a representative of Cigna or its designee that indicates, for example, a particular service is a Covered Expense, is authorized for coverage by the plan, or that you are eligible for coverage is not a guarantee that you will receive benefits for services under this plan. Cigna will make a benefit determination after a claim is received from you or your authorized representative, and the benefit determination will be based on, your eligibility as of the date services were rendered to you and the terms and conditions of the plan in effect as of the date services were rendered to you.

Preservice Determinations

When you or your representative requests a required prior authorization, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's reviewer, in consultation with the treating health care professional, will decide if an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification. If you or your representative attempts to request a preservice determination, but fails to follow Cigna's procedures for requesting a required preservice determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent coverage determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, (if applicable); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and

an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

HC-FED104 01-19

Appointment of Authorized Representative

You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However, Cigna may require you to designate your authorized representative in writing using a form approved by Cigna. At all times, the appointment of an authorized representative is revocable by you. To ensure that a prior appointment remains valid, Cigna may require you to re-appoint your authorized representative, from time to time.

Cigna reserves the right to refuse to honor the appointment of a representative if Cigna reasonably determines that:

- the signature on an authorized representative form may not be yours, or
- the authorized representative may not have disclosed to you all of the relevant facts and circumstances relating to the overpayment or underpayment of any claim, including, for example, that the billing practices of the provider of medical services may have jeopardized your coverage through the waiver of the cost-sharing amounts that you are required to pay under your plan.

If your designation of an authorized representative is revoked, or Cigna does not honor your designation, you may appoint a new authorized representative at any time, in writing, using a form approved by Cigna.

HC-FED88 01-17

Medical - When You Have a Complaint or an 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.

Cigna wants you to be completely satisfied with the care and services you receive. That is why Cigna has established a process for addressing your concerns and solving your problems.

Start With Member Services

Cigna is 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.

Cigna will do our best to resolve the matter on your initial contact. If Cigna needs more time to review or investigate your concern, Cigna 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 Cigna receives an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after Cigna receives an appeal for a postservice coverage determination. If more time or information is needed to make the determination, Cigna 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, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your health care provider 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 reviewer, in consultation with the treating health care provider, 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.

Level-Two Appeal
If you disagree with the decision of Cigna's level-one appeal, you may appeal the decision to the Metro Employee Benefit Board.

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each
qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such

continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
- if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
- if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
- in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

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.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29- month COBRA period).

(Also refer to the section titled "Disability Extension" for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event.

COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

HC-FED66 07-14

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1095 12-17

Ambulance

Licensed ambulance transportation services involve the use of specially designed and equipped vehicles for transporting ill or injured patients. It includes ground, air, or sea transportation when Medically Necessary and clinically appropriate.

HC-DFS1480 01-21

Ancillary Charge

An additional cost, outside of plan cost sharing detailed in The Schedule of Prescription Drug Benefits, which may apply to some Prescription Drug Products when you request a more expensive Brand Drug when a lower cost, Therapeutic Equivalent, Generic Drug is available. The Ancillary Charge
is the amount by which the cost of the requested Brand Drug exceeds the cost of the Generic Drug.

HC-DFS1553 01-21

Biologic

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or
any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS840 10-16

Biosimilar

A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS841 10-16

Brand Drug

A Prescription Drug Product that Cigna identifies as a Brand Drug product across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the plan.

HC-DFS842 10-16

Business Decision Team

A committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to effect changes regarding coverage treatment of Prescription Drug Products and Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, changes regarding tier placement and application of utilization management to Prescription Drug Products and Medical Pharmaceuticals.

HC-DFS1494 07-20

Charges

The term charges means the actual billed charges; except when Cigna has contracted directly or indirectly for a different amount including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers of such services and/or supplies.

HC-DFS1193 01-19

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.

Chiropractic Care

The term Chiropractic Care means 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.

HC-DFS1717 01-22

Convenience Care Clinics

Convenience Care Clinics are staffed by nurse practitioners and physician assistants and offer customers convenient, professional walk-in care for common ailments and routine services. Convenience Care Clinics have extended hours and are located in or near easy-to-access, popular locations (pharmacies, grocery and free-standing locations) with or without appointment.

HC-DFS1629 07-21

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: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

HC-DFS4 04-10
V1

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 placed with an eligible Subscriber by an authorized placement agency or by judgment, decree, or other older 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; 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.

Designated Pharmacy

A Network Pharmacy that has entered into an agreement with Cigna, or with an entity contracting on Cigna's behalf, to provide Prescription Drug Products or services, including, without limitation, specific Prescription Drug Products, to plan enrollees on a preferred or exclusive basis. For example, a Designated Pharmacy may provide enrollees certain Specialty Prescription Drug Products that have limited distribution availability, provide enrollees with an extended days' supply of Prescription Drug Products or provide enrollees with Prescription Drug Products on a preferred cost share basis. A Pharmacy that is a Network Pharmacy is not necessarily a Designated Pharmacy.

HC-DFS1614 01-22

Disability Pensioner

A former Employee receiving disability benefits from Metro.

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who meets the requirements defined in the Domestic Partnership Policy approved by the Board and:

- Both are age 18 or older;
- Both adults currently share a primary residence (i.e., living quarters, although it's not required the residence be listed in both names);
- Both adults have shared a primary residence for the preceding 365 days;
- Both adults are jointly responsible for basic living expenses (food and shelter although the individuals are not required to contribute equally), as demonstrated by a signed Declaration of Domestic Partnership demonstrating financial interdependence and by providing required documentation as showing proof of joint responsibility.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

Effective Date

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

Emergency Medical Condition

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with
respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

HC-DFS1766 01-23

Emergency Services

Emergency Services means, with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or emergency department, as are required to Stabilize the patient.

HC-DFS1764 01-23

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").

Essential Health Benefits

Essential health benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

HC-DFS411 01-11

Expense Incurred

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

HC-DFS10 04-10
V1

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.

A Free-Standing Surgical Facility, unless specifically noted otherwise, is covered with the same cost share as an Outpatient Facility.

HC-DFS1484 01-21

Generic Drug

A Prescription Drug Product that Cigna identifies as a Generic Drug product at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics (including Biosimilars) as either brand or generic based on a number of factors. Not
all products identified as a “generic” by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the plan. A Biosimilar may be classified as a Generic Drug for the purposes of benefits under the plan even if it is identified as a “brand name” drug by the manufacturer, Pharmacy or your Physician.

HC-DFS846 10-16

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.

HC-DFS51 04-10
V1

Hospice Care Services

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

HC-DFS52 04-10
V1

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.

HC-DFS53 04-10
V1

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and 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: specializes in treatment of Mental Health and Substance Use Disorder or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

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

HC-DFS1485 01-21

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 Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

HC-DFS807 12-15

Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

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.

Maintenance Drug Product

A Prescription Drug Product that is prescribed for use over an extended period of time for the treatment of chronic or long-term conditions such as asthma, hypertension, diabetes and heart disease, and is identified principally based on consideration of available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source and clinical factors. For the purposes of benefits, the list of your plan's Maintenance Drug Products does not include compounded medications, Specialty Prescription Drug Products or Prescription Drug Products, such as certain narcotics that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or Refill under applicable federal or state law. You may determine whether a drug is a Maintenance Medication by calling member services at the telephone number on your ID card.

HC-DFS847 10-16

Maintenance Treatment

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

HC-DFS56 04-10
V1

Maximum Reimbursable Charge – Medical

See The Medical Schedule for information about Out-of-Network Charges for Certain Services, Out-of-Network Emergency Services Charges, and Out-of-Network Air Ambulance Services Charges.

The Maximum Reimbursable Charge (also referred to as MRC) is the maximum amount that your plan will pay an Out-of-Network health care provider for a Covered Expense. Your applicable Out-of-Network Copayment, Coinsurance and/or Deductible amount(s), if any, set forth in The Schedule are determined based on the MRC. Unless prohibited by applicable law or agreement, Out-of-Network providers may also bill you for the difference between the MRC and their charges, and you may be financially responsible for that amount. If you receive a bill from an Out-of-Network provider for more than the What I Owe amount on the Explanation of Benefits (EOB), please call Cigna at the phone number on your ID card.

If an Out-of-Network provider is willing to agree to a rate that Cigna, in its discretion, determines to be market competitive, then that rate will become the MRC used to calculate the Out-of-Network allowable amount for a Covered Expense. An Out-of-Network provider can agree to a rate by: (i) entering into an agreement with Cigna or one of Cigna's third-party

vendors that establishes the rate the Out-of-Network provider is willing to accept as payment for the Out-of-Network Covered Expense; or (ii) receiving a payment from Cigna based on an allowed amount that Cigna or one of Cigna's third-party vendors has determined is a market competitive rate without billing you and/or obligating you to pay the difference between the payment amount and the charged amount.

If an Out-of-Network provider does not agree to a market competitive rate as described in the previous paragraph, then the MRC for PPO Plan will be based on an amount required by law, or if no amount is required by law, then the lesser of:

- the providers normal charge for a similar service or supply; or
- the planholder-selected percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable reimbursement for the same or similar service or supply within the geographic market. In the event that Medicare does not have a published rate for a particular service or supply, Cigna may, in its discretion, determine the MRC based on a rate for the same or similar service or supply by applying a Medicare-based methodology that Cigna deems appropriate.

The percentage used to determine the Maximum Reimbursable Charge is 300.

Note: Some providers attempt to forgive, waive, or not collect the cost share obligation (e.g., your Copayment, Coinsurance and/or Deductible amount(s), if any), that this plan requires you to pay. This practice jeopardizes your coverage under this plan. Please read the Exclusions, Expenses Not Covered and General Limitations section, or call Cigna at the phone number on your ID card for more details.

HC-DFS1853 01-24

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.

HC-DFS16 04-10
V1

Medical Pharmaceutical

Medical Pharmaceuticals are used for treatment of complex chronic conditions, are administered and handled in a specialized manner, and may be high cost. Because of their characteristics, they require a qualified Physician to administer or directly supervise administration. Some Medical Pharmaceuticals may initially or typically require Physician oversight but subsequently may be self-administered under certain conditions specified in the product's FDA labeling.

HC-DFS1722 07-22

Medically Necessary/Medical Necessity

Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:

- 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 Professional;
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

In determining whether health care services, supplies, or medications are Medically Necessary, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

HC-DFS1486 01-21

Medicare

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

HC-DFS17 04-10
V1

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Room and Board, made by a Hospital for medical services and supplies actually used during Hospital Confinement.

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

C-DFS1488 01-21

Network Pharmacy

A retail or home delivery Pharmacy that has:

- entered into an agreement with Cigna or an entity contracting on Cigna's behalf to provide Prescription Drug Products to plan enrollees.
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- been designated as a Network Pharmacy for the purposes of coverage under your Employer's plan.

This term may also include, as applicable, an entity that has directly or indirectly contracted with Cigna to arrange for the provision of any Prescription Drug Products the charges for which are Covered Expenses.

HC-DFS1198 01-19

New Prescription Drug Product

A Prescription Drug Product, or new use or dosage form of a previously FDA-approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or newly-approved use or dosage form becomes available on the market following approval by the U.S. Food and Drug Administration (FDA) and ending on the date Cigna makes a Prescription Drug List coverage status decision.

HC-DFS1498 07-20

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."

HC-DFS22 04-10
V1

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.

HC-DFS1489 01-21

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. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS1490 01-21

Participating Provider

The term Participating Provider means a person or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies, the Charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the Charges for which are Covered Expenses.

HC-DFS1194 01-19

Patient Protection and Affordable Care Act of 2010 ("PPACA")

Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

HC-DFS412 01-11

Pensioner

A Regular Pensioner, a Disability Pensioner, or his or her surviving spouse who has met the guidelines to continue to participate in this Plan.

Pharmacy

A duly licensed Pharmacy that dispenses Prescription Drug Products in a retail setting or via home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drug Products through mail order.

HC-DFS851 10-16

Pharmacy & Therapeutics (P&T) Committee

A committee comprised of physicians and an independent pharmacist that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals or Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage determinations made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

HC-DFS1495 07-20

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.

HC-DFS25 04-10
V1

Prescription Drug Charge

The Prescription Drug Charge is the amount that, prior to application of the plan's cost-share requirement(s), the plan sponsor is obligated to pay for a covered Prescription Drug Product dispensed at a Network Pharmacy, including any applicable dispensing fee and tax.

HC-DFS1320 01-19
V1

Prescription Drug List

A list that categorizes Prescription Drug Products covered under the plan's Prescription Drug Benefits into coverage tiers. This list is developed by Cigna based on clinical factors communicated by the P&T Committee and adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.

HC-DFS1775 01-23

Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of benefits under the plan, this definition may also include products in the following categories if specifically identified in the Prescription Drug List:

- Certain durable products and supplies that support drug therapy;
- Certain diagnostic testing and screening services that support drug therapy;
- Certain medication consultation and other medication administration services that support drug therapy; and
- Certain digital products, applications, electronic devices, software and cloud based service solutions used to predict, detect and monitor health conditions in support of drug therapy.

HC-DFS1633 01-22

Prescription Order or Refill

The lawful directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

HC-DFS856 10-16

Preventive Treatment

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

HC-DFS57 04-10
V1

Primary Care Physician

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice OB/GYN or pediatrics; and who has been voluntarily selected by you and is contracted as a Primary Care Physician with, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

HC-DFS40 04-10
V1

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.

HC-DFS26 04-10
V1

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.

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 use disorder professionals, and other trained staff members who perform utilization review services.

HC-DFS808 12-15

Room and Board

The term Room and Board includes all charges made by a Hospital for room and meals and for all general services and activities needed for the care of registered bed patients.

HC-DFS1481 01-21

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.

HC-DFS50 04-10
V1

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: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

HC-DFS31 04-10
V1

Specialist

The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

HC-DFS33 04-10
V1

Specialty Prescription Drug Product

A Prescription Drug Product or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Prescription Drug Product or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug Product or Medical Pharmaceutical has a high acquisition cost; and, whether the Prescription Drug Product or Medical Pharmaceutical is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug Product or Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, or by tier assignment or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-DFS858 10-16

Stabilize

Stabilize means, with respect to an Emergency Medical Condition, to provide medical treatment as necessary to assure that no material deterioration of the condition is likely if the individual is transferred from a facility, or, with respect to a pregnant woman who is having contractions, to deliver.

HC-DFS1768 01-23

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.

HC-DFS54 04-10
V1

Therapeutic Alternative

A Prescription Drug Product or Medical Pharmaceutical that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

HC-DFS859 10-16

Therapeutic Equivalent

A Prescription Drug Product or Medical Pharmaceutical that is a pharmaceutical equivalent to another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

HC-DFS860 10-16

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.

HC-DFS34 04-10
V1

Usual and Customary (U&C) Charge

The usual fee that a Pharmacy charges individuals for a Prescription Drug Product (and any services related to the dispensing thereof) without reference to reimbursement to the Pharmacy by third parties. The Usual and Customary (U&C) Charge includes a dispensing fee and any applicable sales tax.

HC-DFS861 10-16

Member Contribution And Premiums

Employees, Pensioners and other Members of this Plan share in the premium cost of the Plan. The Metropolitan Code of Laws Section 3.16.020 defines how the contribution toward the premium cost is shared. Refer to the charts below for your premium cost for the current plan year.

Premiums for Active Employees

Per pay period		GENERAL GOVERNMENT			MNPS EMPLOYEES	
	Coverage Level	12-month Bi-Weekly	12-month Semi-Monthly	9-month Semi-Monthly	12-month Bi-Weekly	10-month Bi-Weekly
MEDICAL						
PPO	Employee only	$103.38	$112.00	$149.33	$103.38	$134.40
	Employee + child(ren)	$144.92	$157.00	$209.33	$144.92	$188.40
	Employee + family	$265.38	$287.50	$383.33	$265.38	$345.00

Premiums for Pensioners

MEDICAL

All family members WITHOUT Medicare:	PPO PLAN	HRA PLAN
Single	$232.00	$234.00
Pensioner + child(ren) (no spouse coverage)	$338.00	$342.00
Family	$620.00	$628.00

Family members with AND without Medicare:	PPO PLAN	HRA PLAN
Pensioner ***with*** Medicare A + B and Spouse/Partner ***without*** Medicare A + B	$360.00	$381.00
Pensioner ***without*** Medicare A + B and Spouse/Partner ***with*** Medicare A + B	$360.00	$381.00
Pensioner ***without*** Medicare A & B + one child ***with*** Medicare A & B	$360.00	$381.00
Pensioner ***with*** Medicare A & B + child(ren) ***without*** Medicare A & B	$256.00	$294.00
2 of 3 Pensioners ***with*** Medicare A & B	$488.00	$528.00

Premium Cost Share for Metropolitan Council Members

At the end of their term, if a Council Member is a current participant in the plan, coverage may be continued for the Member and their covered dependents. Except as provided below, no member of council serving after October 1, 2027 serving less than 8 years in office, shall be eligible for the subsidized health care plan after leaving office. The premium contributions will be as follows:

- Council Members holding office for less than eight years prior to October 1, 2027 who were participants in the plan may continue coverage, provided they pay the full amount of the premium with no cost share from Metro;
- Council Members serving eight years or more prior to October 1, 2027 and Council members serving prior to September 1, 2007 that serve part of one term and a full consecutive term and were prohibited from serving a third consecutive term are allowed to continue the health care plan, provided they pay the premiums equivalent to those paid by Metro employees;
- Council Members who do not meet the criteria above may continue coverage at the end of their term provided they have served eight years. Their share of premium contribution will be 25% for the first two years, 50% for the next two years, and 75% thereafter.

Pensioner Premium Indexing

Employees hired and non-vested employees rehired on or after January 1, 2013 will have their premiums indexed based upon their credited service at their retirement. Premium cost share information for pensioners is set forth in Metro Code § 3.16.020(C).

Request For Subrogation Or Reimbursement Interest

If you are seeking a personal injury claim against a third-party, the Metropolitan Government of Nashville & Davidson County's Self-Insured Medical Plan ("Plan") may also have a right to recover from your claim any related medical expenses that it has paid on your behalf. These rights are known as the Plan's Subrogation or Reimbursement rights.

Why do I need this Form?

Under Tennessee law, before a judgment or settlement is issued in your personal injury case, you (or your attorney) are required to:

- notify the Plan of your claim; and
- ask the Plan to determine the amount of its Subrogation or Reimbursement interest in your claim.

As a Plan participant, you can use this Form to meet these requirements. If you are being represented by an attorney, then your attorney can complete it and submit it for you.

What is a Subrogation or Reimbursement interest?

When you are injured by a third-party's negligence or other misconduct, you may have certain rights to seek and recover damages from that third-party. Your recovery may include economic damages such as loss of past or future earnings, legal fees, the cost of repairing or replacing personal property, and any medical expenses you incurred as a result of your injuries.

As a Plan participant, the Plan may have already paid part of these same medical expenses on your behalf. The Plan's Subrogation or Reimbursement interest, in general terms, is the Plan's right to recover the relevant medical expenses it paid on your behalf from the damages the third-party ultimately pays to you.

The Plan's Subrogation or Reimbursement interest will reduce the total amount of damages that you get to keep. But remember, the Plan is only recovering amounts it paid for medical expenses that should be the responsibility of the third-party who injured you. Additionally, the Plan may or may not recover the full amount of its Subrogation or Reimbursement interest.

What happens if I do not notify the Plan?

If your attorney is on notice that the Plan has an interest in the judgment or settlement but fails to notify the plan, then up to half of the attorney's interest in your recovery may be forfeited to the Plan.

If you do not have an attorney and you do not provide the required notice to the Plan, the Plan can petition the court for damages to be paid from the proceeds of your recovery. In the court's discretion, these damages can be up to the full amount of the Plan's Subrogation or Reimbursement interest.

How do I complete and submit the Form?

The first step is to fill out the Request for Subrogation or Reimbursement Interest Form with the information requested.

When you are finished, you should make a copy for your (or your attorney's) records.

Please send the completed original Form by **Certified Mail, with return receipt signature or electronic verification**, to the following address:

Metro Human Resources
Attn: Benefits Services Manager
700 President Ronald Reagan Way, Suite 201
Nashville, TN 37210

What happens next?

After receiving the completed Form, the Plan has 90 days to respond in writing to you (or your attorney) with the amount of the Plan's Subrogation or Reimbursement interest, or both.

In some cases, the Plan may need more information or documentation to determine its Subrogation or Reimbursement interest. If so, during this same 90-day period it will send written notice to you (or your attorney) requesting additional information or documentation, and/or notice that additional time is needed.

If the Plan needs more time, it generally will be required to provide written notice of its Subrogation or Reimbursement interest within 180 days of receiving the Form.

However, if you are still undergoing treatment or medical services providers are still in the process of billing for your medical services, the plan may notify you (or your attorney) that it cannot provide the amount of its Subrogation or Reimbursement interest. Either you or your attorney will be responsible for continuing to follow-up with requests for the Plan's Subrogation or Reimbursement interest in these circumstances.

Questions?

If you have additional questions about completing or submitting this Form, or about the Plan's Subrogation or Reimbursement interests or other related matters, please contact the Benefit Services Manager at 615-862-6700.

Request For Subrogation Or Reimbursement Interest

FULL LEGAL NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH (MM/DD/YYYY): _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

PHONE NUMBER: _____

WHEN DID YOUR CLAIM FIRST ARISE (e.g., WHEN WERE YOU INJURED)?

HAVE YOU FILED A CLAIM AGAINST A THIRD-PARTY FOR DAMAGES? IF YES, PLEASE IDENTIFY THE COURT WHERE THE CLAIM WAS FILED, THE CASE NAME, AND THE DOCKET NUMBER.

IF YOU ARE BEING REPRESENTED BY AN ATTORNEY, PLEASE INCLUDE HIS OR HER NAME AND CONTACT INFORMATION IF YOU WOULD LIKE FOR HIM OR HER TO BE INCLUDED ON ANY RELATED PLAN CORRESPONDENCE.

I hereby request the Metropolitan Government of Nashville & Davidson County's Self-Insured Medical Plan ("Plan") to determine the amount, if any, of the Plan's Subrogation or Reimbursement interest in the above reference claim.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

Send by **Certified Mail, with return receipt signature or electronic verification**, to:

Metro Human Resources
Attn: Benefits Services Manager
700 President Ronald Reagan Way, Suite 201
Nashville, TN 37210