CIGNA LIFE INSURANCE COMPANY OF CANADA
CONOCOPHILLIPS COMPANY

OPEN ACCESS PLUS MEDICAL
BENEFITS
PRESCRIPTION DRUG BENEFITS
CIGNA VISION
CIGNA DENTAL PREFERRED
PROVIDER BENEFITS

EFFECTIVE DATE: January 1, 2023

This Certificate contains important information. You should keep it in a safe place.

CN019
06548B
1417891
Global Assignees

This document printed in April 2023 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

These materials are being made available electronically for your convenience. Cigna has provided the final documents to your group. Care should be taken to ensure you are reviewing the most complete, accurate and up to date version. Any questions regarding content may be directed to your group or Cigna.

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Home Office: Scarborough, Ontario
Mailing Address: 100 Consilium Place, Suite 301
Scarborough, Ontario Canada

CIGNA LIFE INSURANCE COMPANY OF CANADA

(herein called Cigna) certifies that it insures certain Members for the benefits provided by the following policy(s):

POLICYHOLDER: CONOCOPHILLIPS COMPANY

GROUP POLICY(S) — COVERAGE

06548B – OPEN ACCESS PLUS MEDICAL BENEFITS
PRESCRIPTION DRUG BENEFITS
CIGNA VISION
CIGNA DENTAL PREFERRED PROVIDER BENEFITS

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NOTICE TO CANADIAN RESIDENTS:
For Members who are residents of Canada, the Insurance described in this Certificate will only be available to the extent that the services/benefits are not covered under a Canadian provincial government health insurance plan.

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.

All benefits payable under this Policy will be made in United States Dollars.

Fong Liang Tsaur
President and Chief Executive Officer

Explanation of Terms

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

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.

Special Plan Provisions

When you select a Participating Provider, the cost for medical services provided will be less than when you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Provider Directory 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.

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

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

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well-being for 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 Group. Contact us for details regarding any such arrangements.

Important Information

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, visit www.cignaenvoy.com or contact customer service at the phone number listed on the back of your ID card.

Notice Regarding Provider Directory

You may obtain a listing of Participating Providers who participate in Cigna's dental network without charge by visiting www.cignaenvoy.com or by calling the toll-free telephone number on your ID card.

How To File Your Claim

There's no paperwork for U.S. 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. U.S. Out-of-Network and International 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 form at www.cignaenvoy.com.

CLAIM REMINDERS

- BE SURE TO USE YOUR ACCOUNT NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL THE CIGNA CLAIM OFFICE.
- YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR ID CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of U.S. Out-of-Network & International Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) for U.S. Out-of-Network and International 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 one year for U.S. Out-of-Network and International 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.

Eligibility - Effective Date

Member Insurance

This plan is offered to you as a Member.

Eligibility for Member Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Members as determined by the group; and
- you pay any required contribution.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

None.

Classes of Eligible Members

The following Classes of Members are eligible for this insurance:

All active Canadian Expatriate and Third Country National Members working outside the United States as reported to the insurance company by the Group.

"Expatriate" means a Member who is working outside his country of citizenship (for U.S. citizens, a member working outside their home country or outside the United States for at least 180 days in a consecutive 12 month period that overlaps with the plan year and their covered dependents).

"Third Country National" generally means a Member of the Policyholder who works outside his country of citizenship, and outside the Policyholder's country of domicile.

Persons for whom coverage is prohibited under applicable law will not be considered eligible under this plan.

Effective Date of Member Insurance

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Dependent Insurance

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date when you become eligible for Member Insurance and your Dependent(s) become eligible for Dependent Insurance and when you elect it by signing an approved payroll deduction or enrollment form, as applicable.

All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 90 days after his birth. If you do not elect to insure your newborn child within such 91 days, coverage for that child will end on the 90th day. No benefits for expenses incurred beyond the 91st day will be payable.

Important Information About Your Medical Plan

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

Opportunity to Select a Primary Care Physician

Choice of 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, we encourage 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.

Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care inside the United States (In & Out-of-Network) and Internationally (outside the United States). To receive, Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Coinsurance, if any.

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 ID 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.

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

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% for the rest of that plan year.

- Coinsurance.

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.
- Provider charges in excess of the Maximum Reimbursable Charge.

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.

Open Access Plus Medical Benefits

The Schedule

U.S. Out-of-Network Emergency Services Charges

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

The member is responsible for applicable U.S. In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges that may be made in excess of the allowable amount. If the U.S. 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.

Arbitration protections available for services rendered in Delaware – If the Emergency Service is rendered in Delaware, the allowable amount may be based on an agreed-upon or negotiated rate. If the provider and Cigna cannot agree on an allowable amount, Cigna or the provider may request arbitration pursuant to Delaware law. Following arbitration, your cost-share may be recalculated to reflect a reduction or increase in the allowable amount determined by the Arbitrator. The provider may not attempt to collect from you any amount in excess of applicable In-Network cost-sharing amounts based upon the allowable amount.

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Lifetime Maximum	Unlimited		
The Percentage of Covered Expenses the Plan Pays	100%	60% of the Maximum Reimbursable Charge of the Maximum Reimbursable Charge	100% of the Maximum Reimbursement Charge; see below
Maximum Reimbursable Charge **Services in the United States** Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; the amount agreed to by the Out-of-Network provider and Cigna, or	Not Applicable	150%	Not Applicable

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Maximum Reimbursable Charge **Services in the United States (Continued)** A percentage of a 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 services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable coinsurance.			

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Note: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable coinsurance.			
Maximum Reimbursable Charge **Services Outside the United States** Maximum Reimbursable Charge for services outside the United States is determined based on the lesser of: • the charges contracted or • otherwise agreed between the provider and Cigna; or • the charge that a provider most often charges patients for the service or procedure; or • the customary charge for the service or procedure as determined by Cigna based upon the range of charges made for the service or procedure by most providers in the general geographic area where the service is rendered or the procedure performed.	Not Applicable	100%	Not Applicable

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Note: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable Coinsurance.			
Calendar Year Out-of-Pocket Maximum Individual Family Maximum **Collective Out-of-Pocket Maximum:** All family members contribute towards the family Out-of-Pocket. An individual cannot have claims covered at 100% until the total family Out-of-Pocket has been satisfied.	 $4,000 per person $8,000 per family	 $8,000 per person $16,000 per family	 $0 per person $0 per family

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Combined Medical/Pharmacy Out-of-Pocket Maximum Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery prescription drugs	Yes	Yes	No
Combined Medical/Vision Out-of-Pocket Maximum	Yes	Yes	No
Emergency Medical Evacuation & Repatriation Benefit Maximum: Unlimited			
Emergency Medical Evacuation	100%	100%	100%
Repatriation Following a Medical Evacuation	100%	100%	100%
Repatriation of Mortal Remains	100%	100%	100%
Emergency Family Travel Arrangements and Confinement Visitation	100%	100%	100%
Return of Dependent Children	100%	100%	100%
Physician's Services			
Physician's Office visit	100%	60% of the Maximum Reimbursable Charge	100%
Surgery Performed In the Physician's Office	100%	60% of the Maximum Reimbursable Charge	100%
Second Opinion Consultations (provided on a voluntary basis)	100%	60% of the Maximum Reimbursable Charge	100%
Allergy Treatment	100%	60% of the Maximum Reimbursable Charge	100%
Preventive Care			
Routine Preventive Care – birth through age 2	100%	100% up to a $1,500 calendar year maximum per person, then 60% of the Maximum Reimbursable Charge	100%
Physician Office Visit Calendar Year Maximum: Unlimited	100%		100%
			100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Routine Preventive Care – ages 3 and older Physician Office Visit Calendar Year Maximum: Unlimited	100%	100% up to a $1,500 calendar year maximum per person, then 60% of the Maximum Reimbursable Charge	100%
Immunizations - birth through age 17 Calendar Year Maximum: Unlimited	100%	100% up to a $1,500 calendar year maximum per person, then 60% of the Maximum Reimbursable Charge	100%
Immunizations – ages 18 and over Calendar Year Maximum: Unlimited	100%	100% up to a $1,500 calendar year maximum per person, then 60% of the Maximum Reimbursable Charge	100%
Immunizations - all ages	100%	100% up to a $1,500 calendar year maximum per person, then 60% of the Maximum Reimbursable Charge	
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings Preventive Care Related Services (i.e. "routine" services)	100%	100% up to a $1,500 calendar year maximum per person, then 60% of the Maximum Reimbursable Charge	100%
Diagnostic Related Services (i.e. "non-routine" services)	100%	60% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Inpatient Hospital - Facility Services	100%	60% of the Maximum Reimbursable Charge	100%
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room 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	Limited to the semi-private room rate (Private Room covered outside the United States only if no semi-private room equivalent is available)
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	100%	60% of the Maximum Reimbursable Charge	100%
Inpatient Hospital Physician's Visits/Consultations	100%	60% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	100%	60% of the Maximum Reimbursable Charge	100%
Emergency Services and Urgent Care			
Urgent Care Services			
Urgent Care Facility	100%	60% of the Maximum Reimbursable Charge	100%
Includes X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit)	100%	50% of the Maximum Reimbursable Charge	100%
Services billed as Emergency Services by an Urgent Care provider will be payable at the In-Network level			
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans, PET Scans, etc.) billed by the facility as part of the UC Visit	100%	50% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Emergency Services			
Physician's Office Visit	100%	100%	100%
Hospital Emergency Room	100%	100%	100%
Outpatient Professional services (radiology, pathology and ER Physician)	100%	100%	100%
X-ray and/or Lab performed at the Emergency Room (billed by the facility as part of the ER visit)	100%	100%	100%
Independent x-ray and/or Lab Facility in conjunction with an ER visit	100%	100%	100%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	100%	100%	100%
Air Ambulance	100%	100%	100%
Ambulance	100%	100% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 120 days combined	100%	60% of the Maximum Reimbursable Charge	100%
Laboratory Services			
Physician's Office Visit	100%	60% of the Maximum Reimbursable Charge	100%
Inpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Laboratory Services at an Independent Lab Facility	100%	60% of the Maximum Reimbursable Charge	100%
Radiology Services			
Physician Office Visits	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient Office Visits	100%	60% of the Maximum Reimbursable Charge	100%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)			
Physician's Office Visit	100%	60% of the Maximum Reimbursable Charge	100%
Inpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Independent X-ray Facility	100%	60% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: Unlimited Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	100%	60% of the Maximum Reimbursable Charge	100%
Chiropractic Care Physician's Office Visit Calendar Year Maximum:	100% Unlimited	60% of the Maximum Reimbursable Charge Unlimited	100% Unlimited
Home Health Care Services Calendar Year Maximum: 120 days (includes outpatient private nursing when approved as medically necessary)	100%	60% of the Maximum Reimbursable Charge	100%
Hospice Inpatient Facility Outpatient Services (same coinsurance level as Home Health Care)	100% 100%	60% of the Maximum Reimbursable Charge 60% of the Maximum Reimbursable Charge	100% 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Bereavement Counseling			
Services provided as part of Hospice Care			
Inpatient	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient	100%	60% of the Maximum Reimbursable Charge	100%
Services provided by Mental Health Professional	Covered under Mental Health Benefit	Covered under Mental Health Benefit	Covered under Mental Health Benefit
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	Covered same as Medical Pharmaceuticals
Inpatient Facility	100%	In-Network Coverage Only	100%
Outpatient Facility	100%	In-Network Coverage Only	100%
Travel Maximum $10,000 per episode of gene therapy	100% (available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy)	In-Network Coverage Only	100% (available only for travel when prior authorized to receive gene therapy at a participating facility specifically contracted with Cigna to provide the specific gene therapy)

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Maternity Care Services			
Initial Visit to Confirm Pregnancy			
Physician Office Visit	100%	60% of the Maximum Reimbursable Charge	100%
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100%	60% of the Maximum Reimbursable Charge	100%
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	100%	60% of the Maximum Reimbursable Charge	100%
Delivery - Facility			
Inpatient Hospital	100%	60% of the Maximum Reimbursable Charge	100%
Birthing Center	100%	60% of the Maximum Reimbursable Charge	100%
Abortion			
Includes elective and non-elective procedures			
Physician's Office Visit	100%	60% of the Maximum Reimbursable Charge	100%
Inpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Women's Family Planning Services			
Office Visits and Counseling	100%	100% up to a $1,500 calendar year maximum per person, then 60% of the Maximum Reimbursable Charge	100%
Lab and Radiology Tests	100%	100% up to a $1,500 calendar year maximum per person, then 60% of the Maximum Reimbursable Charge	100%
Note: Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.			
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)			
Physician's Office Visit	100%	100% up to a $1,500 calendar year maximum per person, then 60% of the Maximum Reimbursable Charge	100%
Inpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Men's Family Planning Services			
Office Visits and Counseling	100%	60% of the Maximum Reimbursable Charge	100%
Lab and Radiology Tests	100%	60% of the Maximum Reimbursable Charge	100%
Surgical Sterilization Procedures for Vasectomy (excludes reversals)			
Physician's Office Visit	100%	60% of the Maximum Reimbursable Charge	100%
Inpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Infertility Treatment Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • 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 Insemination. • cryopreservation, storage, and thawing of sperm, eggs, embryos, and ovarian and testicular tissue. • In-vitro. • GIFT, ZIFT, etc.			
Physician's Office Visits and Counseling	80%	60% of the Maximum Reimbursable Charge	80%
Lab and Radiology Tests	80%	60% of the Maximum Reimbursable Charge	80%
Inpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Lifetime Maximum: $10,000 per member Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).			

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Organ Transplants Includes all medically appropriate, non-experimental transplants			
Physician's Office Visit	100%	60% of the Maximum Reimbursable Charge	100%
Inpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Lifetime Travel Maximum: $10,000 per transplant	No Charge (only available when using LifeSOURCE facility)	Not Covered U.S. In-Network Coverage Only	Not Covered U.S. In-Network Coverage Only
Durable Medical Equipment Calendar Year Maximum: Unlimited	100%	60% of the Maximum Reimbursable Charge	100%
External Prosthetic Appliances Calendar Year Maximum: Unlimited	100%	60% of the Maximum Reimbursable Charge	100%
Hearing Exam Includes hearing exams, diagnosis, testing and fitting of hearing aid devices One examination per 24 month period	100%	60% of the Maximum Reimbursable Charge	100%
Hearing Aid Maximum Up to $1,000 per hearing aid unit necessary for each hearing impaired ear every 3 years for a dependent child under age 24.	100%	60% of the Maximum Reimbursable Charge	100%
Insulin Pumps Calendar Year Maximum: Unlimited	100%	100% of the Maximum Reimbursable Charge	100%
Blood Glucose Meters Calendar Year Maximum: Unlimited	100%	60% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Wigs (for hair loss due to alopecia areata) Calendar Year Maximum: $500	100%	100% of the Maximum Reimbursable Charge	100%
Nutritional Evaluation Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of diabetes.			
Physician's Office Visit	100%	60% of the Maximum Reimbursable Charge	100%
Inpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Nutritional Formulas Unlimited	100%	60% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Genetic Counseling Calendar Year Maximum: 3 visits per person for Genetic Counseling for both pre- and post-genetic testing			
Physician's Office Visit	100%	60% of the Maximum Reimbursable Charge	100%
Inpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.			
Physician's Office Visit	100%	60% of the Maximum Reimbursable Charge	100%
Inpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
TMJ Surgical and Non-surgical Always includes appliances and excludes orthodontic treatment. Subject to medical necessity. Lifetime Maximum (includes office visits, surgery, x-rays/advanced radiological imaging and appliances): $1,000			
TMJ Treatment	Not Covered	Not Covered	Not Covered
Dental Services for Children with Severe Disabilities Medically Necessary specialized treatment and support to secure effective access to dental care for children under age 21 with severe disabilities will be provided at the In-Network benefit level.			

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Obesity/Bariatric Surgery **Note:** Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate. Contact Cigna prior to incurring such costs.			
Physician's Office Visit	100%	60% of the Maximum Reimbursable Charge	100%
Inpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient Facility	100%	60% of the Maximum Reimbursable Charge	100%
Surgical Professional Services Lifetime Maximum; $10,000 **Notes:** • Includes charges for surgeon only; does not include radiologist, anesthesiologist, etc. • Only surgical services accumulate to the maximum			
Alternative Therapies and Non-traditional Medical Services (Outside the United States) Herbalist, Massage Therapist, Naturopath, Acupuncture, Chiropodist			
Physician Office Visit	Not Covered	Not Covered	100%
Calendar Year Maximum: $1,000			

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Routine Foot Disorders Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.			
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.			

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Mental Health			
Inpatient Includes Acute Inpatient and Residential Treatment Calendar Year Maximum: Unlimited	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, etc. Calendar Year Maximum: Unlimited	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient – All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, etc. Calendar Year Maximum: Unlimited	100%	60% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL
Substance Use Disorder			
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Calendar Year Maximum: Unlimited	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient – Office Visits Outpatient – Office Visits Includes Individual, family and group psychotherapy; medication management, etc. Calendar Year Maximum: Unlimited	100%	60% of the Maximum Reimbursable Charge	100%
Outpatient – All Other Services Includes Partial Hospitalization, Intensive Outpatient Services Calendar Year Maximum: Unlimited	100%	60% of the Maximum Reimbursable Charge	100%

Open Access Plus Medical Benefits

Certification Requirements – U.S. 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:

- 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 – U.S. Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and 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 diagnostic testing or 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 nonemergency 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 diagnostic testing or 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 Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Home health care services.
- Medical Pharmaceuticals.
- Radiation therapy.

Prior Authorization/Pre-Authorized U.S.

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;
- outpatient facility services;
- partial hospitalization;
- advanced radiological imaging;
- nonemergency ambulance;
- certain Medical Pharmaceuticals.
- home health care services.
- radiation therapy or
- transplant services.

Covered Expenses

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

- 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 and that are not otherwise excluded from coverage by the terms of this policy.

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 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 licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges incurred in Delaware for School Based Health Centers (SBHCs) at the rate established by the Divisions of Medicaid and Medical Assistance, or an agreed to network participating provider rate.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for 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 made for U.S. FDA approved prescription contraceptive drugs and devices and for outpatient contraceptive services including consultations, exams, procedures, and medical services related to the use of contraceptives and devices.
- charges made for preventive care services.
- charges made for surgical or non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) including appliances and excluding orthodontic treatment.
- charges made for or in connection with mammograms including; a baseline mammogram for asymptomatic women at least age 35; a mammogram every one or two years for asymptomatic women ages 40-49, but no sooner than two years after a woman's baseline mammogram; an annual mammogram for women age 50 and over; and when prescribed by a Physician, a mammogram, anytime, regardless of the woman's age.
- charges made for an annual Papanicolaou laboratory screening (PAP) test.
- charges for developmental screenings at ages 9 months, 18 months, and 30 months. Developmental screenings are any developmental screening tool favorably mentioned in the American Academy of Pediatrics Committee on Children with Disabilities paper on “Developmental Surveillance and Screening of Infants and Young Children” or any other program judged by the Department of Health and Social Services to be an equivalent program.
- charges for newborn screenings.
- charges made for or in connection with baseline lead poison screening or testing, or in connection with lead poison screening, testing, diagnostic evaluation, screening and testing supplies, and home visits for children who are at high risk for lead poisoning according to guidelines set by the Division of Public Health.
- charges for treatment of pediatric autoimmune disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy is required.
- charges for hearing loss screening tests of newborns and infants provided by a Hospital before discharge.

- charges made for insulin pumps, blood glucose meters and diabetes self-management training as recommended in writing or prescribed by a Physician or Other Health Professional.
- ambulance runs and associated basic life support (BLS) services provided by a volunteer ambulance company.
- scalp hair prostheses and wigs worn due to alopecia areata.
- colorectal cancer screening for persons 45 years of age or older or those at high risk of colon cancer because of family history of familial adenomatous polyposis; family history of hereditary non-polyposis colon cancer; chronic inflammatory bowel disease; family history of breast, ovarian, endometrial, colon cancer or polyps; or a background, ethnicity or lifestyle such that the health care provider treating the participant or beneficiary believes he or she is at elevated risk. Coverage will include screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging or other screening modalities established by the American College of Gastroenterology, the American Cancer Society, the United States Preventive Task Force Services, for the ages, family histories and frequencies referenced in such recommendations and deemed appropriate by the attending Physician. Also included is the use of anesthetic agents, including general anesthesia, in connection with colonoscopies and endoscopies performed in accordance with generally accepted standards of medical practice and all applicable patient safety laws and regulations, if the use of such anesthetic agents is Medically Necessary in the judgment of the treating Physician.
- an annual prostate screening (PSA) for men 50 and older.
- CA-125 necessary for monitoring subsequent to ovarian cancer treatment.
- charges made for Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis. Acupuncture services that are not covered include but are not limited to maintenance or treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.
- charges made for hearing aids for Dependent children up to age twenty-four (24).
- charges made for routine hearing exams as shown in The Schedule.
- medical formulas and foods, low protein modified food products, consumed or administered enterally (via tube or orally) which are prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic diseases, such as phenylketonuria (PKU), when administered under the direction of a Physician.
- charges made for or in connection with travel immunization for Members and their Dependents.
- charges for treatment of autism spectrum disorder including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed Physician or a licensed Psychologist: behavioral health treatment; pharmacy care; psychiatric care; psychological care; therapeutic care items and equipment necessary to provide, receive, or advance in the above listed services, including those necessary for applied behavioral analysis; and any care for individuals with autism spectrum disorders that is determined by the Secretary of the Department of Health and Social Services, based upon their review of best practices and/or evidence-based research, to be Medically Necessary.
- charges for specialized treatment or support to secure access to dental care for individuals under age 21 with severe disabilities due to significant mental or physical condition, illness or disease.
- charges for the delivery of telehealth services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state or country and practicing within the health care provider’s scope of practice as would be practiced in-person with a patient, while such patient is at an originating site and the health care provider is at a distant site.
- **Distant site** means a site at which a health care provider legally allowed to practice in the state or country is located while providing health care services by means of telemedicine or telehealth.
- **Originating site** means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth.
- **Store and forward transfer** means the synchronous or asynchronous transmission of a patient's medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

Gene Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure 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 gene therapy; and when the gene therapy products and services directly related to their administration are received at a participating In-Network facility specifically contracted with Cigna for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene 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 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.

Clinical Trials

This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

(b) either

- 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 based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual's participation in such clinical trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service;
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications; and
- routine patient care costs (as defined) for covered persons engaging in clinical trials for treatment of life threatening diseases.

Routine patient care costs do not include:

- the investigational drug, item, device, or service, itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

If your plan includes In-Network providers, Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual's state of residence.

Genetic Testing

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

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

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

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing.

Nutritional Evaluation and Counseling

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

Internal Prosthetic/Medical Appliances

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

Alternative Therapies and Non-traditional Medical Services

Charges for Alternative Therapies and Non-traditional medical services limited to $1,000 per calendar year. Alternative Therapies and Non-traditional medicine include services provided by an Herbalist, Naturopath, Acupuncturist, Chiropodist, or for Massage Therapy when these services are provided for a covered condition outside the United States in accordance with customary local practice and the practitioner is operating within the scope of his/her license, and the treatment is medically necessary, cost-effective, and provided in an appropriate setting.

Obesity Treatment

- charges made for medical and surgical services for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer reviewed, evidence based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities. The following items are specifically excluded:
  - medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity; and
  - weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

Orthognathic Surgery

- orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
  - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease or;
  - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

Home Health Services

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

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

  Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health

Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

Hospice Care Services

Charges 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.

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

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

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

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. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

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

Inpatient Mental Health Services

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

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

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

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

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Partial Hospitalization or Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of

conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment. Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

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

Inpatient Substance Use Disorder Rehabilitation Services

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

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

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

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

Outpatient Substance Use Disorder Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, a group, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program. Substance Use Disorder 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 Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

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

Substance Use Disorder Detoxification Services

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

Exclusions

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

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

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, ventilators, insulin pumps and wheel chairs.

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

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

External Prosthetic Appliances and Devices

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

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

Prostheses/prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts.

Prostheses/prosthetic appliances and devices include, but are not limited to:

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

Orthoses and Orthotic Devices

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

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and 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 will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - no more than once every 24 months for persons 19 years of age and older;
  - no more than once every 12 months for persons 18 years of age and under; and
  - replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

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

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and the services of an embryologist.

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period.

This benefit includes diagnosis and treatment of both male and female infertility and male and female fertility preservation for individuals at verified risk of iatrogenic infertility due to surgery, radiation, chemotherapy or other medical treatment; and female conception.

However, the following are specifically excluded infertility services:

- reversal of male and female voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges and services;
- cryopreservation of donor sperm and eggs; and
- any experimental, investigational or unproven infertility procedures or therapies, unless required by law.

Short-Term Rehabilitative Therapy

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

The following limitation applies to Short-term Rehabilitative Therapy:

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

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.

Multiple outpatient services provided on the same day constitute one day.

Chiropractic Care Services

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

The following limitation applies to Chiropractic Care Services:

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

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by provincial law;
- charges for care not provided in an office setting;
- maintenance or treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- vitamin therapy.

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.

Transplant Services

- charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

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

Transplant Travel Services (U.S. In-Network Coverage Only)

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

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age. The following are specifically excluded travel expenses: any 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 are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available when the covered person is a donor.

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that are 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 which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician or Other Health Professional. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician or Other Health Professional oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

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 benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug Product.

Step Therapy does not apply to FDA approved cancer drugs for the treatment of stage 4 metastatic cancer or any other cancer.

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 Medical Pharmaceuticals as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. Regardless of its eligibility for coverage under your 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 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, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

Prescription Drug Benefits (purchased outside the United States)

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 Drugs or Related Supplies ordered by a Physician outside the United States, Cigna will provide coverage for those expenses as shown in the Medical Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Coinsurance shown in the Schedule. Please refer to the Schedule for any required Coinsurance or Maximums if applicable.

Exclusions:

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by applicable law;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription vitamins (other than prenatal vitamins), and dietary supplements;
- anabolic steroids;
- diet pills or appetite suppressants (anorectics);

- prescription smoking cessation products;
- biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue.

Prescription Drug Benefits

The Schedule

This section describes coverage for Prescriptions obtained inside the United States only.
Prescriptions obtained outside of the United States are covered under the Open Access Plus Medical Benefits section of this certificate.

For You and Your Dependents
This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies requiring a prescription dispensed by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion includes any applicable Coinsurance.

Coinsurance
The term Coinsurance means the percentage of Charges for covered Prescription Drugs and Related Supplies that you or your Dependent are required to pay under this plan.

Charges
The term Charges means the amount charged by the Insurance Company to the plan when the Pharmacy is a Participating Pharmacy, and it means the actual billed charges when the Pharmacy is a non-Participating Pharmacy.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Retail Prescription Drugs	**The amount you pay for each 30-day supply**	**The amount you pay for each 30-day supply**
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no deductible.		
Tier 1 Generic Drugs on the Prescription Drug List	20%	40%
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	20%	40%
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	20%	40%
Home Delivery Prescription Drugs	**The amount you pay for each 90-day supply**	**The amount you pay for each 90-day supply**
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no deductible.		
Tier 1 Generic Drugs on the Prescription Drug List	20%	In-Network coverage only

Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	20%	In-Network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	20%	In-Network coverage only

Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

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 Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription 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.

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply at a retail Pharmacy unless limited by the drug manufacturer's packaging; or
- up to a consecutive 90-day supply at a home delivery Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

Prior Authorization Requirements

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to Cigna to request a prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P&T Committee clinically evaluates the Prescription Drug for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Coinsurance shown in the Schedule. Please refer to the Schedule for any required Coinsurance or Maximums if applicable.

When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for your, or your Dependent’s convenience, a Copayment will apply to each Prescription Drug.

In no event will the Copayment (and any additional costs required by this Plan for the Prescription Drug or Related Supply) or the Coinsurance for the Prescription Drug or Related Supply exceed the amount paid by the plan or the Pharmacy’s Usual and Customary (U&C) charge. Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers, regardless of the customer’s payment source.

Exclusions

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription vitamins (other than prenatal vitamins), dietary supplements unless state or federal law requires coverage of such drugs;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- diet pills or appetite suppressants (anorectics);
- anabolic steroids;
- prescription smoking cessation products, unless such products are described in provincial or federal law as preventive care;
- biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications;
- medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue;
- any drugs that are experimental or investigational as described under the Medical “Exclusions” section of your certificate.

Other limitations are shown in the Medical “Exclusions” section of your certificate.

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail or home delivery (U.S. only) Participating Pharmacy, you pay any applicable Coinsurance shown in the Schedule at the time of purchase. You do not need to file a claim form.

If you or your Dependents purchase your Prescription Drugs or Related Supplies through a non-Participating Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

See your Group's Benefit Plan Administrator to obtain the appropriate claim form.

Emergency Evacuation

If you suffer a life-threatening/limb-threatening medical emergency and, Cigna, and/or its designee, determines that appropriate medical facilities are not available locally, Cigna may arrange for an evacuation to the nearest appropriate facility.

You must contact Cigna at the phone number indicated on your ID card to begin this process. In making their determinations, Cigna, and/or its designee, will consider the nature of the emergency, your condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to the specific Medical Necessity of each case.

Repatriation following a Medical Evacuation

Covered Expenses

Following any covered emergency evacuation, Cigna will pay for **one** of the following:

(1) if it is deemed Medically Necessary and appropriate by the Cigna medical director, you will be transferred to your permanent residence via a one-way economy airfare; or

(2) you will be transferred back to your original work location or the location from which you were evacuated via a one-way economy airfare.

If your transportation needs to be medically supervised a qualified medical attendant will escort you. Additionally, if Cigna, and/or its designee, determines a mode of transport other than economy class seating on a commercial aircraft is required for Medical Necessity reasons, Cigna, or its designee, will arrange accordingly and such will be covered by Cigna.

Notification

Expenses incurred for your evacuation or repatriation without the approval and authorization of Cigna and/or its designee will not be Covered Expenses. Only those expenses approved by Cigna will be eligible for coverage and/or reimbursement under the terms of your plan.

Emergency Family Travel Arrangements and Confinement Visitation

If Cigna determines that you are expected to require hospitalization in excess of 7 days at the location to which you are to be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by you. If your Dependent Child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent child is hospitalized. Only those expenses approved by Cigna and/or its designee prior to occurrence will be eligible for coverage and reimbursement under the terms of your plan.

Return of Dependent Children

If Dependent child(ren) are left unattended by virtue of the evacuee's absence alone following a covered evacuation, a one-way economy airfare will be provided to their place of residence.

Repatriation of Mortal Remains

The costs associated with the transportation of mortal remains from the place of death to the home country will be covered. In addition, assistance will be provided by Cigna or its designee for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

General Limitations/ Exclusions for Evacuation Benefits

No payment will be made for charges for:

- services rendered without the authorization or intervention of Cigna or its designee;
- non-emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to you;
- a condition which would allow for treatment at a future date convenient to you and which does not require emergency evacuation or repatriation;
- medical care or services scheduled for member or provider's convenience which are not considered an Emergency;
- expenses incurred if the original or ancillary purpose of your trip is to obtain medical treatment;
- services provided for which no charge is normally made;
- expenses incurred while serving in the armed forces of another country;
- transportation for your vehicle and/or other personal belongings involving intercontinental and/or marine transportation;
- Expenses incurred in the U.S.;
- service provided other than those indicated in this certificate; or
- claim payments that are illegal under applicable law.

Vision Benefits

The Schedule

For You and Your Dependents

This plan provides Vision Benefits and International Benefits as shown in this Schedule. To receive Vision Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible and Coinsurance if any.

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.

BENEFIT HIGHLIGHTS	UNITED STATES	INTERNATIONAL Outside of United States
Calendar Year Deductible		
Individual	$0	$0
Family	$0	$0
Calendar Year Out-of-Pocket Maximum		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Examinations Once every Calendar Year	**This Plan Will Pay:** 100%	**This Plan Will Pay:** 100%
Lenses & Frames or Contacts One pair of glasses or one supply of contact lenses per Calendar Year Maximum Benefit: $200	100%	100%

Vision Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Vision Benefits, incurs expenses for:

Examinations – one vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses.

Lenses (Glasses) – One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms).

- Polycarbonate lenses for children under 18 years of age;
- Oversize lenses;
- Rose #1 and #2 solid tints;
- Progressive lenses covered up to bifocal lenses amount.

Frames – One frame – choice of frame covered up to retail plan allowance.

Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens materials as well as the cost of supplemental contact lens professional services including fitting and evaluation, up to the stated allowance.

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by a group as a condition of employment.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- Charges in excess of the usual and customary charge or Maximum Reimbursable Charge for the service or materials.
- Magnification or low vision aids.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lens treatments, "add ons", or lens coatings not shown as covered.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- High Index lenses of any material type.
- Lens treatments or "add-ons", except rose tints (#1 & #2), and oversize lenses.
- For or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.
- Claims submitted and received in-excess of one year (365 days) from the original Date of Service.

Other Limitations are shown in the Exclusions and General Limitations section.

Cigna Dental Preferred Provider Insurance

The Schedule

For You and Your Dependents

Preferred Provider Dental Benefits provide coverage for In-Network and Out-of-Network and International Dental Benefits. To receive Preferred Provider Dental Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible and Coinsurance, if any.

The Dental Benefits Plan offered by the Group includes Participating and non-Participating Providers. If you select a Participating Provider, your cost will be less than if you select a non-Participating Provider.

Participating Provider Payment

Participating Provider services are paid based on the Contracted Fee agreed upon by the provider and the Insurance Company.

Non-Participating Provider Payment

Non-Participating Provider services are paid based on the Maximum Reimbursable Charge.

Simultaneous Accumulation of Amounts

Benefits paid for Participating and non-Participating Provider and International services will be applied toward the combined Calendar year maximum shown in the Schedule.

Expenses incurred for either Participating or non-Participating Provider or International charges will be used to satisfy the combined Calendar year Deductible shown in the Schedule.

BENEFIT HIGHLIGHTS	
Classes I, II, III, V Combined Calendar Year Maximum	$2,000
Class IV Lifetime Maximum	$2,000

Cigna Dental Preferred Provider Insurance

The Schedule

Maximum Reimbursable Charge **Services in the United States** Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable Coinsurance.	80^{th} Percentile (Applies to U.S. Out-of-Network)
Maximum Reimbursable Charge **Services Outside the United States** Maximum Reimbursable Charge for services outside the United States is determined based on the lesser of: • the charges contracted or otherwise agreed between the provider and Cigna ; or • the charge that a provider most often charges patients for the service or procedure; or • the customary charge for the service or procedure as determined by Cigna based upon the range of charges made for the service or procedure by most providers in the general geographic area where the service is rendered or the procedure performed. Cigna is not obligated to pay excessive charges. **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable Coinsurance.	100% (Applies to International – Outside the United States)

Cigna Dental Preferred Provider Insurance The Schedule	
Class I Preventive Care	100%
Class II Basic Restorative	80%
Class III Major Restorative	50%
Class IV Orthodontia Class IV Orthodontia applies to Adults and Dependent Children.	50%
Class V Implants	50%

Dental Benefits

Covered Dental Expense

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment.

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, Cigna will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $300.

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Covered Services

The following section lists covered dental services. Cigna may agree to cover expenses for a service not listed. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

Dental PPO – Participating and Non-Participating Providers

Plan payment for a covered service delivered by a Participating Provider is the Contracted Fee for that procedure, times the benefit percentage that applies to the class of service, as specified in the Schedule.

The covered person is responsible for the balance of the Contracted Fee.

Plan payment for a covered service delivered by a non-Participating Provider is the Maximum Reimbursable Charge for that procedure, times the benefit percentage that applies to the class of service, as specified in the Schedule.

The covered person is responsible for the balance of the non-Participating Provider's actual charge.

Class I Services – Diagnostic and Preventive

Clinical oral examination – Only 2 per person per calendar year.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 3 calendar years.

Bitewing x-rays – Only 2 charges per person per calendar year.

Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) – Only 2 per person per calendar year.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Only 1 per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth – Only 1 treatment per tooth in any 3 calendar years.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

Class II Services – Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery

Amalgam Filling

Composite/Resin Filling

Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.

Periodontal Scaling and Root Planing – Entire Mouth

Adjustments – Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recement Bridge

Routine Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.

General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I. V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

Class III Services - Major Restorations, Dentures and Bridgework

Crowns

Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

Bridge Pontics - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Retainer Crowns - Resin with High Noble Metal

Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

Continued active treatment after the first month.

Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

The total amount payable for all expenses incurred for Orthodontics during a person's lifetime will not be more than the Orthodontia Maximum shown in the Schedule.

Class V Services – Implants

Covered Dental Expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired.

Implant coverage may have a separate deductible amount, yearly maximum and/or lifetime maximum as shown in The Schedule.

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- services for which benefits are not payable according to the “General Limitations” section.

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 provincial or federal law to be supplied by or covered by a public program.
- care required by provincial 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.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared, riot, civil commotion or police action which occurs in the Member's country of citizenship.
- Covered Services to the extent that payment is prohibited by applicable law including but not limited to sanctions rules imposed by the United Nations, the European Commission, the United States, and Canada.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Service (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, 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. In the exercise of that discretion, Cigna shall have the right to require you 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. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- charges arising out of or relating to any violation of a healthcare-related provincial, state or federal law or which themselves are a violation of a healthcare-related 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.
  - not considered under the Centers for Medicare and Medicaid's National Coverage Determination List.

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.

The plan or policy shall not deny coverage for a drug therapy or device as experimental, investigational and unproven if the drug therapy or device is otherwise approved by the FDA to be lawfully marketed and is recognized for treatment of the prescribed indication in a prescription drug reference compendium approved by the Insurance Commissioner or substantially accepted peer reviewed medical literature and is considered under the Centers for Medicare and Medicaid's National Coverage Determination List.

- 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: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- reversal of male or female voluntary sterilization procedures.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- non-medical counseling and/or ancillary services, including but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, and wigs other than for scalp hair prostheses worn due to alopecia areata.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as covered under this plan as shown in the Covered Expenses section . A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in

anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

- blood administration for the purpose of general improvement in physical condition.
- cosmetics, dietary supplements and health and beauty aids.
- all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.

General Limitations

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

- for charges made for any service that is not covered by the terms of this policy or for coverage declined, or otherwise not elected by you, at enrollment.
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the Canadian government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program.
- to the extent that payment is unlawful or prohibited by applicable sanctions rules;
- for elective or pre-scheduled treatment in sanctioned countries;
- for any Members whom the Insurance Company considers to be ordinarily resident in a sanctioned country. Members are considered ordinarily resident if they visit a sanctioned country for a period of longer than 6 weeks over the course of any 12 month period.for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your family or your Dependent's Family.

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. For claims incurred within Canada, you should file all claims under each Plan. For claims incurred outside Canada, if you file claims with more than one Plan, you must indicate, at the time of filing a claim under this Plan, that you also have or will be filing your claim under another 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, dental or vision 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 any government health insurance plan.
- 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

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a 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 a member 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 member;
- 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 member (or as that member's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired member (or as that member'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 provincial law shall be the Secondary Plan and the Plan that covers you as an active member or retiree (or as that member'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 province 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.

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 we are 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 we request, you must execute and deliver to us such instruments and documents as we determine 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 we request 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 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

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, or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault 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.
- 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.

Payment of Benefits - Medical & Vision

Assignment and Payment of Benefits

You may 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 Services 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 or the Office of the Public Trustee. If no request for payment has been made by his legal guardian or the Office of the Public Trustee, 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 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 within twenty-four (24) months after the payment is made. The 24 month limit will not apply if there is reasonable belief of fraud, abuse, or other international misconduct, or if required by a state or federal government plan. 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.

Payment of Benefits - Dental

To Whom Payable

Dental Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian or the Office of the Public Trustee. If no request for payment has been made by his legal guardian or the Office of the Public Trustee, 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.

Notice of Right to Designate Beneficiaries

This policy contains a provision removing or restricting the right of the group person insured to designate persons to whom or for whose benefit insurance money is to be payable.

Termination of Insurance - Members

Your insurance will cease on the earliest date below:

- the last day of the calendar month you cease to be in a Class of Eligible Members or cease to qualify for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date determined by the Group. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Group stops paying premium for you or otherwise cancels your insurance.

Retirement

If your Active Service ends because you reture, your insurance will be continued until the date on which the Group stops paying premium for you or otherwise cancels the insurance**.**

Termination of Insurance - Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the last day of the calendar month your insurance ceases.
- The last day of the calendar month you cease to be eligible for Dependent Insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

Dependent Medical Insurance After Your Death

If you are insured for Medical Insurance when you die, any of your Dependents who are then insured for such insurance, except a Dependent who is eligible for Medicare, will remain so insured without further payment of premiums for them. The insurance on any of those Dependents will remain in force until the earliest date below:

- the last day of the 3rd month after your death;
- the date of remarriage of a surviving spouse, if any;
- the date that Dependent qualifies for Medicare;
- the date that Dependent ceases to qualify as a Dependent for a reason other than lack of primary support by you.

The Dependent benefits payable after you die will be those in effect for your Dependents on the day prior to your death.

Medical Benefits Extension During Hospital Confinement Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy (except if policy is canceled for nonpayment of premiums), 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
- 10 days from the date the policy is canceled.

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.

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

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 properly authorized by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the service you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a quality of service, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Cigna Global Health Benefits Service Center at 1-800-441-2668 (inside the United States and Canada or 302-797-3100 (outside the United States, call collect). You should state the reason(s) why you feel your claim should have been approved. Please have your customer ID available to assist the representatives in expediting your inquiry.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. Our representatives may provide instructions or directions to pursue your issue including, but not limited to utilization of the appeals procedure outlined below. Notwithstanding that, these representatives will remain available for continued information related to your concerns.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Insurance Company within 180 days (in the case of any claim for disability benefits) from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing, within 365 days of receipt of a denial notice, to the address below:

However, if Cigna reduces or terminates coverage (except where the reduction or termination is due to a plan amendment or termination) for an ongoing course of treatment that Cigna previously approved, and the reduction or termination in coverage will occur before the end of the period of time or number of treatments that Cigna approved, then to initiate an appeal you must submit a request for an appeal of that reduction or termination in coverage within 30 days of receipt of the denial notice. If you appeal timely a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna

Attn: Appeals Department

P.O. Box 15800

Wilmington, DE 19850

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 to register your appeal by telephone. Call us at us at the Cigna Global Health Benefits Service Center at 1-800-441-2668 (inside the United States and Canada or 302-797-3100 (outside the United States, call collect).

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 in the same or similar specialty as the care under consideration, as determined by Cigna's Physician Reviewer.

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

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is

expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal set forth above. Your level two appeal should reference the specific details or conclusions included in the decision letter you received in response to your level one appeal.

If the appeal involves a coverage decision based on issues of Medical Necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician Reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician Reviewer. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was not involved in any previous decision related to your appeal, and not a subordinate of previous decision makers. Provide all relevant documentation with your second-level appeal request.

For required preservice and concurrent care coverage determinations, Cigna's review will be completed within 15 calendar days. For postservice claims, Cigna's review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level-two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the decision within five days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

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 function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician Reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Review of Medical Appeals – Cigna's Ombudsman

If you are not fully satisfied with the decision of Cigna's level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you can contact Cigna's Ombudsman in writing at:

CLIC Ombudsman Liaison
100 Consilium Place, Suite 301
Scarborough, Ontario, Canada M1H 3E3
Email: ombudsmanCLICCanada@Cigna.com
Fax: 1.416.290.0732

A decision to use this level of appeal will not affect the claimant's rights to any other benefits under the plan.

To be eligible for review by Cigna's Ombudsman you must have completed Steps 1 and 2 outlined above. After Cigna's Ombudsman has reviewed your appeal, we will send you a written response within 30 days of receipt of the appeal by the Ombudsman. If more time or information is needed to make the determination, we will notify you in writing to request an extension and to specify any additional information needed to complete the review. The Ombudsman's response is considered Cigna's final position on the appeal and will not be reopened or reconsidered internally unless you provide additional information that was not previously reviewed in reaching the decision.

Claim Appeal to the Industry OmbudService and/or The Financial Consumer Agency of Canada

You have the right to appeal a claim denial to the OmbudService for Life and Health Insurance ("OHLI") that provides information and resources on issues that have not been resolved through Cigna's internal complete process. Information regarding this resource is available at http://olhi.ca/ or OHLI can be contacted at 1.888.295.8112 (English) or 1.866.582.2088 (French).

You may also contact the Financial Consumer Agency of Canada ("FCAC") that ensures federally regulated entities comply with consumer provision measures and raises awareness of their rights and responsibilities. FCAC can be

contacted regarding your appeal through its website at www.fcac-acfc.gc.ca.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action; 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 appeal, 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 information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Action Against Cigna

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (Alberta and B.C.). Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time out in the Limitations Act (Ontario), and otherwise within such a longer period as may be required under the law applicable in the covered person’s province.

Definitions

Active Service

You will be considered in Active Service:

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

Bed and Board

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

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).

Certification

The term Certification means a decision by a health care insurer that a health care service requested by a provider or covered person has been reviewed and, based upon the information available, meets the health care insurer's requirements for coverage and medical necessity, and the requested health care service is therefore approved.

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna 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.

Chiropodist

See Podiatrist

Chiropractic Care

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

Contracted Fee - Cigna Dental Preferred Provider

The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on an Member or Dependent, according to the Member's dental benefit plan.

Country of Citizenship

Country of Citizenship is the nation of the Member or Dependents' birth or the country in which they have subsequently been naturalized or granted legal citizenship or recognition.

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.

Dentally Necessary

Services provided by a Dentist or Physician as determined by Cigna are Dentally Necessary if they are:

- required for the diagnosis and/or treatment of the particular dental condition of disease; and
- consistent with the symptom or diagnosis and treatment of the dental condition or disease; and
- commonly and usually noted throughout the dental field as proper to treat the diagnosed dental condition or disease; and
- the most fitting level or service which can safely be given to you or your Dependent.

A diagnosis, treatment, and service with respect to a dental condition or disease, is not Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a provider operating within the scope of his license when he performs any of the Dental Services described in the policy.

Dependent

Dependents are:

- your lawful spouse including someone to whom you're married or someone with whom you co-habitate in a conjugal relationship; and
- any child of yours who is
  - less than 26 years old;
  - 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap.

    Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. During the next two years Cigna may, from time to time, require proof of the continuation of such condition and dependence. After that, Cigna may require proof no more than once a year.

A child includes a legally adopted child. It also includes a stepchild.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as a Member will not be considered as a Dependent spouse. A child under age 26 may be covered as either a Member or as a Dependent child. You cannot be covered as a Member while also covered as a Dependent of an Member.
No one may be considered as a Dependent of more than one Member.

Emergency Services - Medical

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, or other provider, including ancillary services routinely available to the emergency department or to another provider to evaluate the Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the providers and facilities available to Stabilize the patient. A provider for Emergency Services is a licensed Physician, a licensed Nurse, a licensed physician assistant, a licensed nurse practitioner, a licensed diagnostic facility, a licensed clinical facility, a licensed Hospital and an urgent care center.

Expense Incurred

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

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.

Group

The term Group means an eligible organization or plan sponsor to which the policy is issued.

Home Country

Home Country is the nation in which the Member or Dependents have their permanent place of residence prior to an expatriate assignment and/or the indefinite intention to reside post assignment.

Herbalist

The term Herbalist means a non-medical practitioner who specializes in treating disorders with natural remedies derived exclusively from plant materials.

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.

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 jurisdiction in which it operates.

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; or
- 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 will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

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

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Use Disorder Services in a Residential Treatment Center.

Injury

The term Injury means an accidental bodily injury.

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 plans 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 Drug Product by calling member services at the telephone number on your ID Card.

Massage Therapist

The term Massage Therapist means a person who is licensed to apply manipulation, methodical pressure, friction and kneading to the body.

Maximum Reimbursable Charge (MRC) –Dental and Vision

Services in the United States

The term Maximum Reimbursable Charge (MRC) means the charge for a covered service which is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

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

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

Maximum Reimbursable Charge – Medical, Dental, Vision and Pharmacy

Services Outside the United States

Maximum Reimbursable Charge for services outside the United States is determined based on the lesser of:

- the charges contracted or otherwise agreed between the provider and Cigna; or
- the charge that a provider most often charges patients for the service or procedure; or
- the customary charge for the service or procedure as determined by Cigna based upon the range of charges made for the service or procedure by most providers in the general geographic area where the service is rendered or the procedure performed. Cigna is not obligated to pay excessive charges.

Maximum Reimbursable Charge - Medical

Services in the United States

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply;
- the amount agreed to by the Out-of network provider and Cigna; or
- a 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 within the geographic market.

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

In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply;
- the amount agreed to by the Out-of-Network provider and Cigna; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.

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

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

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

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.

Member

The term Member means a full-time employee as determined by the Group who is currently in Active Service.

Naturopath

The term Naturopath means a non-medical practitioner who specializes in treating conditions by making reforms to the diet and lifestyle of the patient.

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any charges, by whomever

made, for the administration of anesthetics during Hospital Confinement.

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

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."

Ophthalmologist

The term Ophthalmologist means a person practicing ophthalmology within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

Optician

The term Optician means a fabricator and dispenser of eyeglasses and/or contact lenses. An optician fills prescriptions for glasses and other optical aids as specified by optometrists or ophthalmologists. The state in which an optician practices may or may not require licensure for rendering of these services.

Optometrist

The term Optometrist means a person practicing optometry within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

Other Health Care Facility/Other Health Professional

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. The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable provincial 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.

Participating Pharmacy

The term Participating Pharmacy means a retail Pharmacy with which Cigna has contracted to provide prescription services to insureds, or a designated home delivery Pharmacy with which Cigna has contracted to provide home delivery prescription services to insureds. A home delivery Pharmacy is a Pharmacy that provides Prescription Drugs through mail order.

Participating Provider - Dental

The term Participating Provider means: a dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a contract with Cigna to provide dental services at predetermined fees.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by the Group. Services received from Participating Providers are considered In-Network.

Participating Provider – Medical

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 in the U.S., 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. Covered services and/or supplies received from Participating Providers are considered In-Network.

Pharmacy

The term Pharmacy means a retail Pharmacy, or a home delivery Pharmacy.

Physician

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

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

Podiatrist

The term Podiatrist means a licensed practitioner responsible for the examination, diagnosis, prevention, treatment and care of conditions and functions of the human foot. A Podiatrist performs surgical procedures, prescribes corrective devices, drugs and physical therapy.

Prescription Drug

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

Prescription Drug Charge

The Prescription Drug Charge is the amount that, prior to application of the plan's cost-share requirement(s), is payable by Cigna to its Pharmacy Benefit Manager for a specific covered Prescription Drug Product dispensed at a Network Pharmacy, including any applicable dispensing fee and tax. The "Pharmacy Benefit Manager" is the business unit, affiliate, or other entity that manages the Prescription Drug Benefit for Cigna.

Prescription Drug List

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

Prescription Order

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

Preventive Treatment

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

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 selected by you and is contracted as a Primary Care Physician, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

Related Supplies

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

Review Organization

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

Sickness – For Medical Insurance

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

Skilled Nursing Facility

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

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

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such

treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

Stabilize

Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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.

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.

Vision Provider

The term Vision Provider means: an optometrist, ophthalmologist, optician or a group partnership or other legally recognized aggregation of such professionals; duly licensed and in good standing with the relevant public licensing bodies to provide covered vision services within the scope of the Vision Providers' respective licenses.