Adelphi University

COMPREHENSIVE MEDICAL BENEFITS Major Medical Indemnity Retiree Only

EFFECTIVE DATE: January 1, 2021

ASO6 3336505

This document printed in November, 2020 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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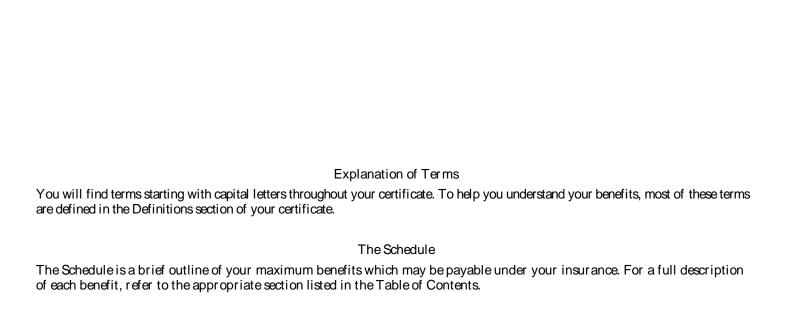
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Important Information

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

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

HC-NOT89





Care Management and Care Coordination Services Your plan

myCigna.com

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

HC-NOT96 07-17

Proficiency of Language Assistance Services

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

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

Chinese

Cigna ID 1.800.244.6224 711 Vietnamese

Korean : ,

ID

1.800.244.6224

Cigna

(TTY: 711)

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

Russian

(TTY: 711).



French Creole ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki

dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French AT

sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre

1.800.244.6224 (ATS: composez le numéro 711).

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

Polish

identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711). Japanese

Cigna ID 1.800.244.6224 TTY:

711

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

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



НС



mental health or substance use disorder (MH/SUD) benefits in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, those used in applying the NQTL to medical/surgical benefits in the same classification of benefits as written and in operation under the terms of the plan.

Non-Quantitative Treatment Limitations (NQTLs) include:

Medical management standards limiting or excluding benefits based on Medical Necessity or whether the treatment is experimental or investigative;

Prescription drug formulary design;

Network admission standards;

Methods for determining in-network and out-of-

<u>myCigna.com</u>

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Comprehensive Medical Benefits

The Schedule

For You and Your Dependents

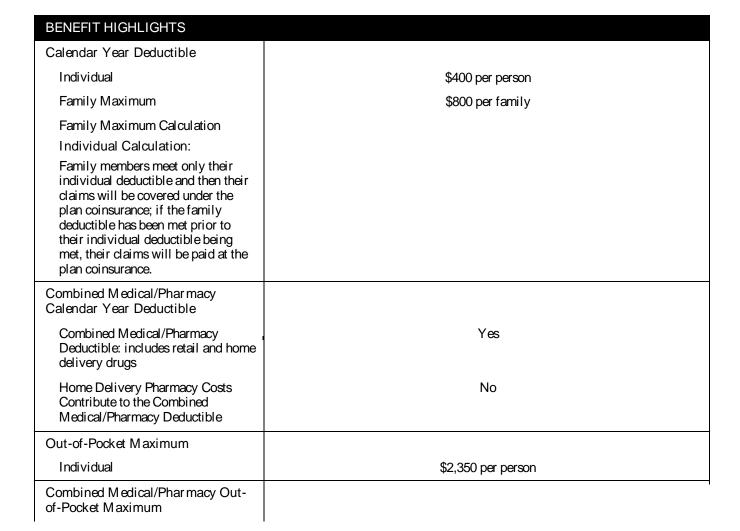
To receive Comprehensive Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible and Coinsurance.

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.

Deductibles

Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this plan. Deductibles are in addition to any Coinsurance. Once the Deductible m





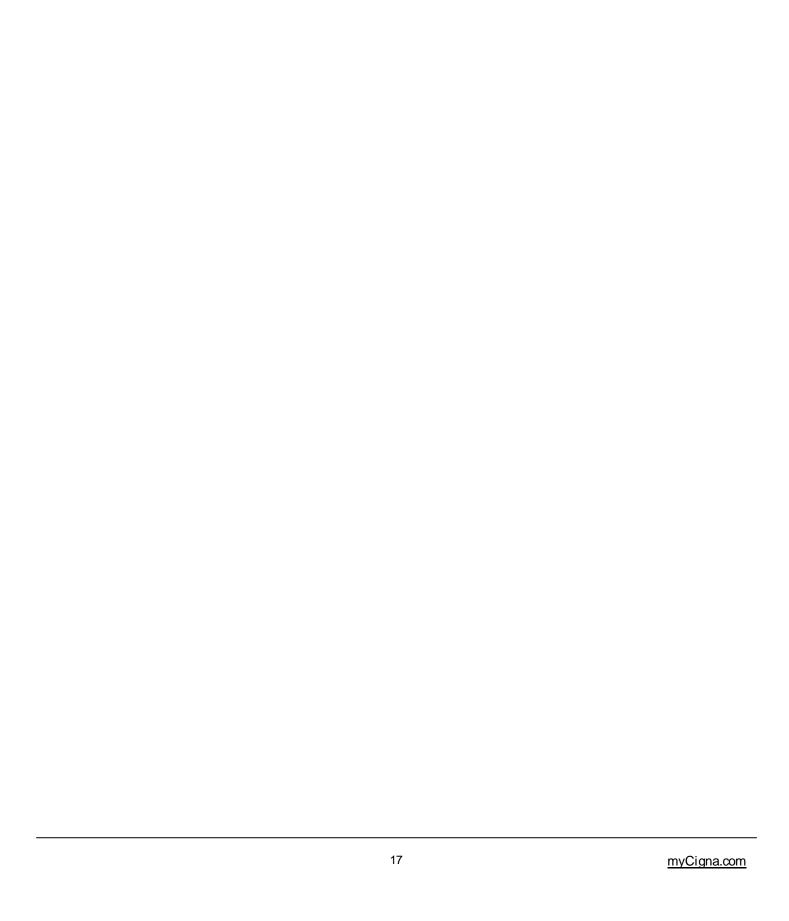
BENEFIT HIGHLIGHTS	
Visit	Plan deductible, then 80%
Visit	Plan deductible, then 80%
Services	
Note: OB/GYN providers will be considered either as a PCP or Specialist.	
Surgery Performed in the	
Primary Care Physician	Plan deductible, then 80%
Specialty Care Physician	Plan deductible, then 80%



BENEFIT HIGHLIGHTS	
Virtual Care	
Dedicated Virtual Providers	
Services available through contracted	
virtual providers as medically appropriate.	
Virtual Care Services for minor medical conditions	Plan deductible, then 80%
Virtual Wellness Screenings Note:	100%
Lab services supporting a virtual wellness screening must be obtained through dedicated labs.	
Virtual Physician Services	
Services available through Physicians as medically appropriate.	
Note: Preventive services covered at the preventive level.	
Primary Care Phys Visit	Plan deductible, then 80%
Visit	Plan deductible, then 80%
Preventive Care	
Note:	
Includes coverage of additional service standard Preventive Care benefit.	es, such as urinalysis, EKG, and other laboratory tests, supplementing the
Routine Preventive Care for children t	hrough age 2 (including immunizations)
	Plan deductible, then 80%
Visit	
Visit	Plan deductible, then 80%
Immunizations	
	Plan deductible, then 80%
Visit	Tier deadonolo, thereove
Visit	Plan deductible, then 80%



BENEFIT HIGHLIGHTS	
Mammograms, PSA, PAP Smear	
Preventive Care Related Services	Subject -ray benefit & lab benefit; based on place of service
Diagnostic Related Services (i.e.	-ray benefit & lab benefit; based on place of service
Inpatient Hospital - Facility Services	Not Applicable
Semi-Private Room and Board	Limited to the semi-private room rate
Private Room	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the ICU/CCU daily room rate
Outpatient Facility Services	
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room Note: Covers Bithing Centers	Plan deductible, then 80%





BENEFIT HIGHLIGHTS	
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)	
Visit	Plan deductible, then 80%
Specialty Car Visit	Plan deductible, then 80%
Inpatient Facility	Not Applicable
Outpatient Facility	Plan deductible, then 80%
Outpatient Therapy Services	

Calendar()]TJETQalendl2IILFH



BENEFIT HIGHLIGHTS Home Health Care Services



BENEFIT HIGHLIGHTS

Gene Therapy

Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary.

Gene Therapy Product

Inpatient Facility

Outpatient Facility

Inpatient Professional Services

Outpatient Professional Services

Covered same as Medical Pharmaceuticals

Not Applicable

Plan deductible, then 80%

Not Applicable

Plan deductible, then 80%



Maternity Care Services Initial Visit to Confirm Pregnancy Note: OB/GYN providers will be considered either as a PCP or Specialist. Primary Care Physicia Visit Plan deductible, then 80% Visit

All subsequent Prenatal Visits,

Delivery Charges (i.e. global

FIT HIGHLIGHTS ce Visits, Lab and Radiology s and Counseling udes coverage for contraceptive ces (e.g., Depo-Provera and auterine Devices (IUDs)) as red or prescribed by a rician. Diaphragms also are



BENEFIT HIGHLIGHTS

Infertility Services

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.

Surgical Treatment: Limited to procedures for the correction of infertility (excludes In-vitro, GIFT, ZIFT, etc.)

Surgical Treatment: Limited to procedure	es for the correction of infertility (excludes In-vitro, GIFT, ZIFT, etc.)
Radiology Tests, Counseling)	
Primary Care Physician	Plan deductible, then 80%
Specialty Care Physician	Plan deductible, then 80%
Inpatient Facility	Not Applicable
Outpatient Facility	Plan deductible, then 80%
Inpatient Professional Services	Not Applicable
Outpatient Professional Services	Plan deductible, then 80%
Organ Transplants Includes all medically appropriate, non-experimental transplants	
Visit	Plan deductible, then 80%
Specialty Care Physic Visit	Plan deductible, then 80%
Inpatient Facility	Not Applicable
Inpatient Professional Services	Not Applicable
Lifetime Travel Maximum: \$10,000 per transplant	100% (only available when using LifeSOURCE facility)
Durable Medical Equipment	Plan deductible, then 80%
Calendar Year Maximum: Unlimited	
Breast Feeding Equipment and Supplies	100%
Note: Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	



BENEFIT HIGHLIGHTS	
Hearing Aids Calendar Year Maximum: \$5,000 every 36 months	Plan deductible, then 80%
Wigs Calendar Year Maximum: Unlimited	Plan deductible, then 80%
Dental Care	
Limited to charges made for a continuous course of dental treatment started within six months of an injury to teeth.	
Visit	Plan deductible, then 80%
Specialty Care Physician Visit	Plan deductible, then 80%
Inpatient Facility	Not Applicable
Outpatient Facility	Plan deductible, then 80%
Inpatient Professional Services	Not Applicable
Outpatient Professional Services	Plan deductible, then 80%
TMJ Surgical and Non-Surgical	
Always excludes appliances and orthodontic treatment.	
Visit	Plan deductible, then 80%
Visit	Plan deductible, then 80%
Inpatient Facility	Not Applicable
Outpatient Facility	Plan deductible, then 80%
Inpatient Profe Speech Therapy ssional Services	Not Applicable
Outpatient Professional Services	Plan deductible, then 80%



BENEFIT HIGHLIGHTS

Bariatric Surgery

Note:

Subject to any limitations shown in the

Expenses Not Covered

this certificate.

Plan deductible, then 80% Visit

Plan deductible, then 80% Visit

Inpatient Facility Not Applicable

Outpatient Facility Plan deductible, then 80%

Inpatient Professional Services Not Applicable

Outpatient Professional Services Plan deductible, then 80%



BENEFIT HIGHLIGHTS	
Mental Health	
Inpatient	Plan deductible, then 80%
Includes Acute Inpatient and Residential Treatment	
Calendar Year Maximum: Unlimited	
Outpatient	
Outpatient - Office Visits	Plan deductible, then 80%
Includes individual, family and group psychotherapy; medication management, virtual care, etc.	
Calendar Year Maximum: Unlimited	
Outpatient - All Other Services	Plan deductible, then 80%
Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc.	
Calendar Year Maximum: Unlimited	



BENEFIT HIGHLIGHTS Substance Use Disorder Plan deductible, then 80% Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Calendar Year Maximum: Unlimited Outpatient Outpatient - Office Visits Plan deductible, then 80% Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited Outpatient - All Other Services



Comprehensive Medical Benefits

Certification Requirements

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



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

Covered Expenses

charges for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital, subject to the limits as shown in The Schedule.

charges for inpatient Room and Board and other Necessary Services and Supplies made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility as shown in The Schedule.

charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.

charges for outpatient medical care and treatment received at a Hospital.

charges for outpatient medical care and treatment received at a Free-Standing Surgical Facility.

charges for Emergency Services.

charges for Urgent Care.

charges by a Physician or a Psychologist for professional services.

charges by a Nurse for professional nursing service.

charges for anesthetics, including, but not limited to supplies and their administration.

charges for diagnostic x-ray.

charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and



for services or supplies that are primarily to aid you or your Dependent in daily living.

HC-COV980 01-21

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



a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program.

Substance Use Disorder Partial Hospitalization Services are rendered no less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program



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.

HC-COV8 04-10

External Prosthetic Appliances and Devices

charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect.

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

Prostheses/Prosthetic Appliances and Devices

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

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

Orthoses and Orthotic Devices

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

- Non-foot orthoses only the following non-foot orthoses are covered:
 - rigid and semi-rigid custom fabricated orthoses;
 - semi-rigid prefabricated and flexible orthoses; and
 - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses custom foot orthoses are only covered as follows:
 - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
 - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;

when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and

for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

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

Braces

V2

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

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

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- replacement due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited as follows:

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



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

The following are specifically excluded external prosthetic appliances and devices:

external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and



To improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions. Includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.



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.

HC-COV482 12-15

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that are administered in an Inpatient setting, Outpatient , 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. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the

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 first.

Utilization management requirements or other coverage conditions are based on a number of factors, which may include clinical and economic factors. Clinical factors may inclu



Gene therapy products and their administration are covered when prior authorized.

HC-COV873 01-20

Clinical Trials

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

the referring health care professional is a participating

participation in such trial would be appropriate; or the individual provides medical and scientific information

qualified trial would be appropriate.

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

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

it is federally funded trial. The study or investigation is approved or funded (which may include funding through inkind contributions) by one or more of the following:

National Institutes of Health (NIH)



For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a Deductible, Copayment or Coinsurance requirement for Covered Expenses for Prescription Drug Products.

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

Coinsurance

The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.

Copayments (Copay)

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

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY			
Lifetime M aximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule			
Calendar Year Deductible					
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule			
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule			
Out-of-Pocket Maximum					
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule			
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule			
Maintenance Drug Products	Maintenance Drug Products				
Certain Preventive Care Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required.					
Prescription Drug Products at Retail Pharmacies	The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy			

Certain Specialty Prescription Drug Products are only covered when dispensed by a home delivery Pharmacy, after 1 fill of the Specialty Prescription Drug Product at a retail Pharmacy.



BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Tier 1		
Generic Drugs on the Prescription Drug List	Non-Maintenance Drug Products: 20%	Non-Maintenance Drug Products: 20% after plan Deductible
	Maintenance Drug Products: 20% for the first 2 fills, then no coverage for a 30-day supply	Maintenance Drug Products: 20% after plan Deductible for the first 2 fills, then no coverage for a 30-day supply
Tier 2		
Brand Drugs designated as preferred on the Prescription Drug List	Non-Maintenance Drug Products: 20%	Non-Maintenance Drug Products: 20% after plan Deductible

Maintenance Drug Products: 20% for the first 2 fills, then no coverage for a 30



BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Tier 3 Brand Drugs designated as non- preferred on the Prescription Drug List	20%	20% after plan Deductible
December 1 as December 1	The amount was a sufer on the 25 Court	1

Prescription Drug Products at Home Delivery Pharmacies

The amount you pay for up t oo5.6 rrt



Prescription Drug Benefits

Covered Expenses

Your plan provides benefits for Prescription Drug Products dispensed by a Pharmacy. D

Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations, and Exclusions are provided below and/or are shown in The Schedule.

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

enefits also

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

When you or a Dependent are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered pursuant to the, as applicable, Copayment or Coinsurance for the Prescription Drug Product when dispensed by a Network Pharmacy.

Prescription Drug List Management

Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. Determination of inclusion of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and utilization management requirements or other coverage conditions are based on a number of factors which may include, clinical and economic factors. Clinical factors may include, but are not

therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug

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submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. You can obtain a claim form through the website shown on your ID card or by calling member services at the telephone number on your ID card.

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered



wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Additionally, charges made by a Physician for any of the following Surgical Procedures are covered: excision of unerupted impacted wisdom tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth).

for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the Body Mass Index (BMI) classifications of the National Heart, Lung, and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:

medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and

weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

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.

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,



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.

dental implants for any condition.

fees associated with the collection or



Closed Panel Plan



Qualified Medical Child Support Order Defined

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

group health benefits for which a participant or beneficiary is eligible;

the order specifies your name and last known address, and

name and address of an official of a state or political subdivision may be s address;

the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

the order states the period to which it applies; and

if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

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

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the

parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

HC-FED4 10-10

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act



Concurrent Determinations

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

Postservice Determinations

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

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the

action under section 502(a) of ERISA following an adverse benefit determination on appeal, (if applicable); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

HC-FED104 01-19

Appointment of Authorized Representative

You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However, Cigna may require you to designate your authorized representative in writing using a form approved by Cigna. At

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if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or

in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

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

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries.

How Much Does COBRA Continuation Coverage Cost? Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. For example: If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

continuation rights under the Plan.

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the The COBRA coverage election notice will list the indivindual(s)-17(n)6(thm)dTidE,TQBQTVi01 (b)4 @144@ntabdTraee period of 30 days after t BThe

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 $policy(s). \ A \ subsequent \ Plan \ termination \ will \ not \ affect \ the \\ extension \ of \ benefits \ and \ rights \ under \ the \ policy(s).$

on the earliest of the following dates:

the date you leave Active Service (or later as explained in the



Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf Cigna is providing claim administration services.

HC-DFS8 04-10

V1



Hospital

The term Hospital means:

an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;

an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or

an institution which: specializes in treatment of Mental Health and Substance Use Disorder or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

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

HC-DFS1485 01-21

Hospital Confinement or Confined in a Hospital

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

a registered bed patient in a Hospital upon the recommendation of a roec((iz)-12(es7 1 12(s)3(e)-4(Dis)-8(o)-5E0 0 1 39.72 35-3(r)-3()-2(r(o)aTm[A)11(B()-2(is)4()-2(ac)-3(cr)TBT1 0 0



Medicaid

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

HC-DFS16 04-10

Medical Pharmaceutical

An FDA-approved prescription pharmaceutical product, including a Specialty Prescription Drug Product, typically required to be administered in connection with a covered service by a Physician or Other Health Professional within the scope of the provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Physician oversight but may be self-administered under certain conditions specified in the

ot include any

charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA



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

HC-DFS1198 01-19

New Prescription Drug Product

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

HC-DFS1498 07-20

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abb term



performing a service for which benefits are provided under this plan when performed by a Physician.

HC-DFS25 04-10 V1

Prescription Drug Charge
The Prescription Drug Charge is the amount that, prior to



