AURA

CIGNA MEDICARE SURROUND

EFFECTIVE DATE: January 1, 2018

CN046
3328775

This document printed in February, 2018 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
THIS IS NOT A STANDARDIZED MEDICARE SUPPLEMENT PLAN

HC-IMP75
10-10
V1
# Table of Contents

Certification ................................................................................................................................. 5

Important Notices ...................................................................................................................... 7

How To File Your Claim ............................................................................................................. 8

Eligibility - Effective Date .......................................................................................................... 9

  Insurance for Eligible Persons ................................................................................................. 9
  Insurance for Dependents ........................................................................................................ 9

Cigna Medicare Surround ......................................................................................................... 10

  The Schedule .......................................................................................................................... 10
  Covered Expenses ................................................................................................................... 20

Exclusions .................................................................................................................................. 21

Payment of Benefits .................................................................................................................. 22

Termination of Insurance .......................................................................................................... 22

  Eligible Persons ..................................................................................................................... 22
  Dependents ............................................................................................................................. 22

Federal Requirements .............................................................................................................. 23

  Qualified Medical Child Support Order (QMCSO) ............................................................... 23
  Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA) .................................................................................................................... 23
  Coverage for Maternity Hospital Stay ................................................................................... 24
  Women’s Health and Cancer Rights Act (WHCRA) ............................................................... 25
  Coordination with Medicare .................................................................................................. 25
  Claim Determination Procedures under ERISA ................................................................. 25
  COBRA Continuation Rights Under Federal Law ................................................................. 26
  ERISA Required Information ............................................................................................... 29

Definitions .................................................................................................................................... 31

Certificate Rider .......................................................................................................................... 34
CIGNA HEALTH AND LIFE INSURANCE COMPANY
a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Association of Universities for Research in Astronomy Inc

GROUP POLICY(S) — COVERAGE
3328775 - MEDG1 CIGNA MEDICARE SURROUND

EFFECTIVE DATE: January 1, 2018

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.

Anna Krishtul, Corporate Secretary

HC-CER1 04-10
V1
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.
Important Notices

**Discrimination is Against the Law**

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

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

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

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

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

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

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


**Proficiency of Language Assistance Services**

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

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

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


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


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

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

**French** – ATTENTION: Des services d’aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de
Additional Programs
We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to Eligible Persons and their Dependents for the purpose of promoting their general health and well being. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

How To File Your Claim
Upon enrollment, for smoother claim payment, you should provide Cigna with your Medicare Claim Number as it appears on your Medicare I.D. card. You can:

- Enter it at myCigna.com
- Call Cigna Customer Service at the number on the back of your Cigna I.D. card.

You must submit expenses covered by this plan to Medicare before they can be considered for payment under this plan. Hospitals, Skilled Nursing Facilities, home health agencies, and Physicians are required by law to file Medicare claims for covered services and supplies that you receive.

If you visit your doctor or hospital, your doctor or hospital will send a claim directly to Medicare. Medicare will pay their part and will send the claim to Cigna. You will receive a Medicare Summary Notice (MSN) from Medicare. The Summary Notice will list your Medicare claims information including a note if the information was sent to your private insurer (Cigna) for additional benefits.

For services not covered by Medicare but covered by this plan, you will need to send a claim form to Cigna. You may get the required claim forms from your Benefit Plan Administrator, by calling customer service or from our website at www.Cigna.com. All fully completed claim forms and bills should be mailed directly to the claim address that appears on the back of your Cigna ID card.

CLAIM REMINDERS
- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA’S CLAIM FORMS, OR WHEN YOU CALL CIGNA CUSTOMER SERVICE.
- YOUR MEMBER ID IS THE ID SHOWN ON YOUR CIGNA IDENTIFICATION CARD.
- YOUR CIGNA ACCOUNT/GROUP NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR CIGNA IDENTIFICATION CARD. PROVIDE YOUR
MEDICARE CLAIM IDENTIFICATION NUMBER AS IT APPEARS ON YOUR MEDICARE ID CARD.
BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Eligibility Restrictions
The Eligible Person must enroll for coverage under either this plan or a Related Plan in order to enroll for Dependent Insurance.

Eligibility - Effective Date

Insurance for Eligible Persons
This plan is offered to you as an Eligible Person. To be insured, you may have to pay part of the cost.
You will become eligible for insurance on the day you are in a Class of Eligible Persons.

Classes of Eligible Persons
Each Eligible Person as reported to the insurance company by your Employer.

Effective Date of Your Insurance
You will become insured on the date you elect the insurance by completing the application process, but no earlier than the date you become eligible.
You will become insured on your first day of eligibility, following your election.

Insurance for Dependents
For your Dependents to be insured, you may have to pay part of the cost of 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.

Effective Date of Dependent Insurance
Insurance for your Dependents will become effective on the date you elect it by completing the application process, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.
## Cigna Medicare Surround
### (Part A and Part B)

#### The Schedule

**For You and Your Dependents**
Part A benefits cover the same benefits covered under Medicare Part A. Part B benefits cover the same benefits covered under Medicare Part B. Unless otherwise noted, the benefits covered under this plan are limited to expenses approved by Medicare but not paid by Medicare. To receive benefits, you and your Dependents must pay a portion of the Covered Expenses. That portion is the Deductible and Coinsurance.

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

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

**Out-of-Pocket Expenses**
Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Part A or Part B expenses for:
- Coinsurance
- Deductible

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

### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Lifetime Maximum</th>
<th>PART A EXPENSES</th>
<th>PART B EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applies to Part A and B expenses</td>
<td>Unlimited</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

### Coinsurance Levels

<table>
<thead>
<tr>
<th>Part A</th>
<th>Part B Deductible</th>
<th>Remainder of expenses after the Part B Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coinsurance as shown below of the amount approved by Medicare but not paid by Medicare</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
</tbody>
</table>

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myCigna.com
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>PART A EXPENSES PLAN PAYS</th>
<th>PART B EXPENSES PLAN PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part B Excess Charges</strong></td>
<td>Not Applicable</td>
<td>100% after plan deductible up to the Medicare limiting charge, or the Maximum Reimbursable Charge whichever is less</td>
</tr>
<tr>
<td>Charges above approved Medicare amounts for providers that do not accept the Medicare assignment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximum Reimbursable Charge</strong></td>
<td>Not Applicable</td>
<td>80th Percentile</td>
</tr>
<tr>
<td>Maximum Reimbursable Charge is determined based on the lesser of the provider’s normal charge for a similar service or supply; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The provider may bill you for the difference between the provider’s normal charge and the Maximum Reimbursable Charge, in addition to any applicable deductibles and coinsurance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td>Not Applicable</td>
<td>$183 per person</td>
</tr>
<tr>
<td>(Applies to Part B expenses only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
<td>$500 per person</td>
</tr>
<tr>
<td>(Applies to Part A and Part B expenses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital - Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-private room and board, general nursing and miscellaneous services and supplies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A new benefit period begins each time the member is out of the hospital more than 60 days</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days 1 - 150 per benefit period (using 60 lifetime reserve days)</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>PART A EXPENSES PLAN PAYS</td>
<td>PART B EXPENSES PLAN PAYS</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Once Lifetime Reserve days are used (or would have ended if used) additional 365 days of confinement per person per lifetime</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Inpatient Services at Other Health Care Facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</td>
<td>Medicare pays in full.</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>First 20 days</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
<td></td>
</tr>
<tr>
<td>21st – 100th day</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Hospice/Inpatient Respite Care (includes Bereavement Counseling)</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>Not Applicable</td>
<td>$10 PCP per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>Not Applicable</td>
<td>$10 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Surgery Performed In the Physician’s Office</td>
<td>Not Applicable</td>
<td>$10 PCP or $10 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Second Opinion Consultations (provided on a voluntary basis)</td>
<td>Not Applicable</td>
<td>$10 PCP or $10 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Allergy Treatment/Injections</td>
<td>Not Applicable</td>
<td>$10 PCP or $10 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>PART A EXPENSES PLAN PAYS</td>
<td>PART B EXPENSES PLAN PAYS</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>---------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Routine Physical exam age 18 and over (includes certain screenings). Also covers a one time per lifetime “Welcome to Medicare” exam.</td>
<td>Not Applicable</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Immunizations age 18 and over (includes flu shots, hepatitis B shots and Pneumococcal shots)</td>
<td>Not Applicable</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td><strong>Shingles Vaccine</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Applicable</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Early Cancer Detection Screenings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Applicable</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td><strong>Outpatient Facility Services – Surgical Facility and Free Standing Ambulatory Surgery Center</strong></td>
<td>Not Applicable</td>
<td>$10 per visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Operating Room, Recovery Room, Procedures Room and Treatment Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Facility Services Non-Surgical Facility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including, but not limited to radiation therapy, chemotherapy, x-ray, MRI, CT Scan, PET Scan or lab services when done in an outpatient hospital facility</td>
<td>Not Applicable</td>
<td>$10 per visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Physician’s Visits/Consultations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Applicable</td>
<td>$10 PCP or $10 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Professional Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon/Assistant Surgeon Radioiologist Pathologist Anesthesiologist</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td><strong>Outpatient Professional Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon/Assistant Surgeon Radioiologist Pathologist Anesthesiologist</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
</tbody>
</table>

**Notes:**
- Preventive Care includes annual routine physical exam for age 18 and over (includes certain screenings), one time per lifetime “Welcome to Medicare” exam, and immunizations for age 18 and over (includes flu shots, hepatitis B shots, and Pneumococcal shots).
- Outpatient Facility Services include Surgical Facility and Free Standing Ambulatory Surgery Center, Outpatient Facility Services Non-Surgical Facility, Inpatient Hospital Physician’s Visits/Consultations, Inpatient Hospital Professional Services, and Outpatient Professional Services.
- Plan pays 100% of the amount approved by Medicare but not paid by Medicare for Preventive Care and Outpatient Facility Services Non-Surgical Facility.
### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Emergency and Urgent Care Services</th>
<th>PART A EXPENSES PLAN PAYS</th>
<th>PART B EXPENSES PLAN PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office Visit</td>
<td>Not Applicable</td>
<td>$10 PCP or $10 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>Not Applicable</td>
<td>$50 per visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Emergency Room Physician</td>
<td>Not Applicable</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Urgent Care Facility or Outpatient Facility</td>
<td>Not Applicable</td>
<td>$10 per visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)</td>
<td>Not Applicable</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Independent X-ray and/or Lab Facility in conjunction with an ER visit</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
</tbody>
</table>

### Laboratory, Radiology Services and Advanced Radiological Imaging

(includes diagnostic tests, pre-admission testing, MRIs, MRAs, CAT Scans and PET Scans)

<p>| Physician’s Office                | Not Applicable            | $10 PCP or $10 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare |
| Outpatient Hospital Facility      | Not Applicable            | 100% after plan deductible of the amount approved by Medicare but not paid by Medicare |
| Independent X-ray and/or Lab Facility | Not Applicable | 100% after plan deductible of the amount approved by Medicare but not paid by Medicare |</p>
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>PART A EXPENSES</th>
<th>PART B EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Short-Term Rehabilitative Therapy and Chiropractic Care Services</strong></td>
<td>Not Applicable</td>
<td>$10 PCP or $10 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Maximum: Unlimited up to Medicare limits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
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<tr>
<td>Speech Therapy</td>
<td></td>
<td></td>
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<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
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<tr>
<td>Chiropractic Therapy (includes Chiropractors)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary Rehab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>Not covered by plan. Medicare pays in full.</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Maximum: Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity Care Services</strong></td>
<td>Not Applicable</td>
<td>$10 PCP or $10 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Initial Visit to Confirm Pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: OB/GYNs are considered Specialists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All subsequent Prenatal Visits, Postnatal Visits and Physician’s Delivery Charges (i.e. global maternity fee)</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Office Visits in addition to the global maternity fee when performed by an OB/GYN or specialist</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Delivery - Facility</td>
<td>Same as plan’s Inpatient Hospital Facility benefit</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>(Inpatient Hospital)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Birthing Center)</td>
<td>Not Applicable</td>
<td>Same as plan’s Outpatient Surgical Facility benefit</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>PART A EXPENSES PLAN PAYS</td>
<td>PART B EXPENSES PLAN PAYS</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Abortion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes non-elective procedures only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>Not Applicable</td>
<td>$10 PCP or $10 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Same as plan’s Inpatient Hospital Facility benefit</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Not Applicable</td>
<td>Same as plan’s Outpatient Facility benefit</td>
</tr>
<tr>
<td>Inpatient Physician’s Services</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Outpatient Physician’s Services</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td><strong>Family Planning Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Sterilization Procedure for Vasectomy/Tubal Ligation Limited to Medicare covered services (excludes reversals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office</td>
<td>Not Applicable</td>
<td>$10 PCP or $10 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Same as plan’s Inpatient Hospital Facility benefit</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Not Applicable</td>
<td>Same as plan’s Outpatient Facility benefit</td>
</tr>
<tr>
<td>Inpatient Physician’s Services</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Outpatient Physician’s Services</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
</tbody>
</table>
### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th><strong>Infertility Treatment</strong></th>
<th><strong>PART A EXPENSES</strong></th>
<th><strong>PART B EXPENSES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Services Not Covered include:</td>
<td>Not Applicable</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Testing performed specifically to determine the cause of infertility.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Artificial means of becoming pregnant are (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:**
Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.

<table>
<thead>
<tr>
<th><strong>Organ Transplants</strong></th>
<th><strong>PART A EXPENSES</strong></th>
<th><strong>PART B EXPENSES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes all medically appropriate, non-experimental transplants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Same as plan’s Inpatient Hospital Facility benefit</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Inpatient Physician’s Services</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Outpatient Physician’s Services</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Travel Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Durable Medical Equipment</strong></th>
<th><strong>PART A EXPENSES</strong></th>
<th><strong>PART B EXPENSES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum: Unlimited</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>External Prosthetic Appliances</strong></th>
<th><strong>PART A EXPENSES</strong></th>
<th><strong>PART B EXPENSES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum: Unlimited</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Diabetic Supplies and Services</strong></th>
<th><strong>PART A EXPENSES</strong></th>
<th><strong>PART B EXPENSES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>PART A EXPENSES PLAN PAYS</td>
<td>PART B EXPENSES PLAN PAYS</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>Not Applicable</td>
<td>$10 PCP or $10 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Same as plan’s Inpatient Hospital Facility benefit</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Not Applicable</td>
<td>Same as plan’s Outpatient Facility benefit</td>
</tr>
<tr>
<td>Inpatient Physician’s Services</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Outpatient Physician’s Services</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td><strong>Dental Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to Medicare covered services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>Not Applicable</td>
<td>$10 PCP or $10 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Same as plan’s Inpatient Hospital Facility benefit</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>Not Applicable</td>
<td>Same as plan’s Outpatient Surgical Facility benefit</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td><strong>TMJ Surgical and Non-surgical</strong></td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Routine Foot Disorders</strong></td>
<td>Not Applicable</td>
<td>$10 PCP or $10 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Includes only services associated with foot care for diabetes and peripheral vascular disease.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blood</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First 3 pints in a calendar year</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Additional amounts per calendar year</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>PART A EXPENSES PLAN PAYS</td>
<td>PART B EXPENSES PLAN PAYS</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td><strong>Hearing Aids</strong></td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Calendar Year Maximum: 1 hearing aid per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum Amount: $1,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Part B Covered Prescription Drugs</strong></td>
<td>Not Applicable</td>
<td>100% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td><strong>Smoking Cessation Counseling</strong></td>
<td>Not Applicable</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Same as plan’s Inpatient Hospital Facility benefit</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Therapy</td>
<td>Not Applicable</td>
<td>$10 PCP per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>Not Applicable</td>
<td>$10 PCP per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td><strong>Foreign Travel</strong></td>
<td>Not Applicable</td>
<td>80% after foreign travel deductible</td>
</tr>
<tr>
<td>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Deductible: $250</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum: $50,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Hearing Exam</strong></td>
<td>Not Applicable</td>
<td>$10 per office visit deductible then 100% up to the Maximum Reimbursable Charge</td>
</tr>
<tr>
<td>Calendar Year Maximum: 1 routine exam per year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Cigna Medicare Surround

Covered Expenses

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

- charges made by a Hospital for Part A Medicare Eligible Expenses for a Hospital Confinement from the first day through the 150th day in any Medicare Benefit Period (includes 60 lifetime reserve days).
- charges made by a Hospital for a Hospital Confinement for an additional 365 days per benefit period per person per lifetime once the lifetime reserve days are used (or would have ended if used).
- charges made by a Skilled Nursing Facility, rehabilitation hospital and sub-acute facilities for Part A Medicare Eligible Expenses from the 21st day through the 100th day in any Medicare Benefit Period. A person must have been in the Hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the Hospital.
- charges made for Hospice/Inpatient Respite Care for Part A Medicare Eligible Expenses which includes bereavement counseling for a terminally ill person.
- charges made for Part A Medicare Eligible Expenses for the first 3 pints of blood in a calendar year or equivalent quantities of packed red blood cells as defined under federal regulations unless replaced in accordance with federal regulations.
- charges made for Part A Medicare Eligible Expenses for additional amounts of blood after the first 3 pints in a calendar year.
- charges made for outpatient short-term rehabilitative therapy.
- charges made for home health care services.
- charges made for maternity.
- charges made for family planning surgical related services.
- charges made for durable medical equipment and external prosthetic appliances.
- charges made for diabetic supplies, including but not limited to: blood glucose test strips, blood glucose monitor, lancet devices and lancets, glucose control solutions for checking accuracy of test strips and monitors and therapeutic shoes or inserts.
- charges made for clinical trials.
- charges made in an outpatient facility, emergency room or urgent care facility.
- charges made for ambulance services.
- charges made for routine foot disorders for diabetes and peripheral vascular disease when Medically Necessary.
- charges made for prescription drugs including but not limited to: antigens, osteoporosis drugs, erythropoiesis, blood clotting factors, injectable drugs, immunosuppressive drugs, oral cancer drugs, and oral anti-nausea drugs.
- charges for smoking cessation counseling.
- charges made for mental health and substance abuse.
- charges made for organ transplants.

- charges made for immunizations.
- charges for the following Early Cancer Detection Screenings including but not limited to:
  - pap test and pelvic examination;
  - prostate cancer screening and digital exam;
  - mammogram screening;
  - colonoscopy;
  - sigmoidoscopy;
  - fecal blood test; and
  - barium enema.
- charges made for Part B Medicare Eligible Expenses for the first 3 pints of blood in a calendar year or equivalent quantities of packed red blood cells as defined under federal regulations unless replaced in accordance with federal regulations.
- charges made for Part B Medicare Eligible Expenses for additional amounts of blood after the first 3 pints in a calendar year.
- charges made for outpatient short-term rehabilitative therapy.
- charges made for home health care services.
- charges made for maternity.
- charges made for family planning surgical related services.
- charges made for durable medical equipment and external prosthetic appliances.
- charges made for diabetic supplies, including but not limited to: blood glucose test strips, blood glucose monitor, lancet devices and lancets, glucose control solutions for checking accuracy of test strips and monitors and therapeutic shoes or inserts.
- charges made for clinical trials.
- charges made in an outpatient facility, emergency room or urgent care facility.
- charges made for ambulance services.
- charges made for routine foot disorders for diabetes and peripheral vascular disease when Medically Necessary.
- charges made for prescription drugs including but not limited to: antigens, osteoporosis drugs, erythropoiesis, blood clotting factors, injectable drugs, immunosuppressive drugs, oral cancer drugs, and oral anti-nausea drugs.
- charges for smoking cessation counseling.
- charges made for mental health and substance abuse.
- charges made for organ transplants.
• charges made for dental care.
• charges made for any Foreign Travel Emergency Services deductible and for the charges remaining after any such deductible. Covered Expenses will include any Emergency Services that begin within the first 60 days of travel outside the United States in a year.
• Part B Excess charges for providers who do not accept Medicare assignment after any Medicare Part B Deductible is met. Coverage will be provided for the difference between the actual Medicare Part B charge as billed and the Medicare approved Part B charge.
• charges made for a routine hearing exam.
• charges made for hearing aids, including but not limited to semi-implantable hearing devices, auricular bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
• care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
• treatment of an Injury or Sickness which is due to war, declared, or undeclared.
• charges which you are not obligated to pay 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 or in connection with experimental, investigational or unproven services.

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:
• any expense that is:
  • not a Medicare Eligible Expense; or
  • beyond the limits imposed by Medicare for such expense; or
• excluded by name or specific description by Medicare; except as specifically provided under the “Covered Expenses” section or any other portion of this certificate including any riders attached.
• any portion of a Covered Expense to the extent paid or payable by Medicare;
• any benefits payable under one benefit of this plan to the extent payable under another benefit of this plan;
• Covered Expenses incurred after coverage terminates.

In addition, the following exclusions apply to any service that is a Covered Expense under this plan, but is not covered by Medicare:
• care for health conditions that are required by state or local law to be treated in a public facility.
• care required by state or federal law to be supplied by a public school system or school district.
• cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.
• 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.
• private Hospital rooms and/or private duty nursing.
• 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.
- blood administration for the purpose of general improvement in physical condition.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- massage therapy.

**General Limitations**

- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- expenses 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.
- expenses incurred outside the United States other than expenses for medically necessary urgent or emergent care while temporarily traveling abroad.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

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

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

**Recovery of Overpayment**

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

**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**

**To Whom Payable**

Medical Benefits are assignable to the provider if the provider does not participate with Medicare. 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. All claims for providers that participate with Medicare will be assigned to the provider.

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

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

**Termination of Insurance**

**Eligible Persons**

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of EligiblePersons or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.

**Dependents**

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

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
• the last day for which you have made any required contribution for the 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.

Federal Requirements

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

All references in this section to "Employee" shall be deemed to mean "Eligible Person".

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order, provided the child is otherwise eligible under this plan. You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

• Acquiring a new Dependent. If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and
Dependent child(ren). Enrollment of Dependent children is limited to the adopted children or children who became Dependent children of the Employee due to marriage.

- **Loss of eligibility for State Medicaid or Children’s Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.

- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan’s network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.

- **Termination of Employer contributions (excluding continuation coverage).** If a current or former Employer ceases all contributions toward the Employee’s or Dependent’s other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).

- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the Employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan’s service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an Employer’s limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

- **Eligibility for employment assistance under State Medicaid or Children’s Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

**Except as stated above, special enrollment must be requested within 31 days after the occurrence of the special enrollment event. If the special enrollment event is the adoption of a Dependent child, coverage will be effective immediately on the date of adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.**

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

**Coverage for Maternity Hospital Stay**

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

**Women’s Health and Cancer Rights Act (WHCRA)**

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

**Coordination with Medicare**

Benefits provided under this plan will not duplicate any benefits paid by Medicare. Determination of the amount payable under this plan will be based upon the difference between the amount paid by Medicare and the Medicare Approved Amount (for Part A) or the Maximum Reimbursable Charge (for Part B).

**Eligibility for Medicare**

This plan will assume the amount payable under Part A and/or Part B of Medicare for a person who is eligible for but is not currently enrolled in that Part(s), or Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract. A person is considered to be eligible for Medicare on the earliest date any coverage under Medicare could become effective for that person.

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**Claim Determination Procedures under ERISA**

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

**Procedures Regarding Medical Necessity Determinations**

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

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

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

**Preservice Determinations**

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

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna’s reviewer, in consultation with the treating health care professional, will decide if an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.
However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow Cigna’s procedures for requesting a required preservice determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

**Concurrent Determinations**

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

**Postservice Determinations**

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

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

**Notice of Adverse Determination**

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

**COBRA Continuation Rights Under Federal Law**

**For You and Your Dependents**

**What is COBRA Continuation Coverage?**

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

**When is COBRA Continuation Available?**

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

- The Employer files Bankruptcy under Title 11 of the United States Code.

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

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.
Who is Entitled to COBRA Continuation?
Only a “qualified beneficiary” (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

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

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

Disability Extension
If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

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

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

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

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

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

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

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse’s) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.

- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

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

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

How Much Does COBRA Continuation Coverage Cost?

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

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% of the active Employee premium. 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

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 payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

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 month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a
payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

**You Must Give Notice of Certain Qualifying Events**

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

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.

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

**Newly Acquired Dependents**

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

**COBRA Continuation for Retirees Following Employer’s Bankruptcy**

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

**Interaction With Other Continuation Benefits**

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

**ERISA Required Information**

The name of the Plan is:

Aura Inc Group Health Plan

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

Association of Universities for Research in Astronomy Inc
PO Box 26732
950 N Cherry Ave.
Tucson, AZ 85726
(520) 318-8158

Employer Identification Number (EIN): 860138043

Plan Number: 509

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.
The Plan’s fiscal year ends on 12/31.
The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

**Plan Trustees**

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

**Plan Type**

The plan is a healthcare benefit plan.

**Collective Bargaining Agreements**

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a
sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority
The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination
The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the plan. A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan’s insurance policy(s) will end on the earliest of the following dates:
- the date you leave Active Service (or later as explained in the Termination Section);
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights
As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
- examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage
- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan...
and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Domestic Partner
A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;

Definitions
Dependent
Dependents are:

- your lawful spouse who is eligible for Medicare; or
- your Domestic Partner who is eligible for Medicare; and
- any unmarried child of yours who is eligible for Medicare by reason of disability who is:
  - 18 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. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you who is eligible for Medicare by reason of disability. It also includes a stepchild who lives with you. If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent if they are eligible for Medicare.

Benefits for a Dependent child will continue until the date in which the Medicare beneficiary ceases to be medicare eligible.

No one will be considered as a Dependent of more than one Eligible Person.

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• is currently legally married to another person; or
• has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

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

Eligible Person
The term Eligible Person means a former employee, a retiree or terminated employee of the Employer who is eligible for Medicare by reason of age or disability.

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

Employer
The term Employer means the Policyholder and all Affiliated Employers.

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

Hospice Care Services
The term Hospice Care Services means any Medicare Eligible Expenses 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.

Hospital
The term Hospital means:
• an institution that is approved by Medicare and has agreed to participate in Medicare.
• 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 Abuse 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.

Injury
The term Injury means an accidental bodily injury.

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

- the provider’s normal charge for a similar service or supply; or
- a policyholder-selected 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.

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.

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

Medicare Approved Amount
The term Medicare Approved Amount means the amount in the Original Medicare Plan that a Physician or supplier can be paid, including what Medicare pays and any deductible, coinsurance or copayment that you pay. It may be less than the actual amount charged by a Physician or supplier.

Medicare Eligible Expenses
The term Medicare Eligible Expenses means expenses covered by Medicare to the extent recognized as reasonable by Medicare.
Medicare Part A Benefit Period
The term Medicare Part A Benefit Period means a period of
time during which a Medicare beneficiary is Hospital or
Skilled Nursing Facility confined. A Medicare Benefit Period:
• begins when a Medicare beneficiary is admitted to a
Hospital as an inpatient; and
• ends when he or she has not been Confined in a Hospital or
Skilled Nursing Facility for 60 consecutive days.

Medicare Part A Deductible
Medicare Part A Deductible means the deductible amount that
you are required to pay under Medicare for expenses incurred
at the beginning of a Medicare Part A Benefit Period.

Medicare Part B Deductible
Medicare Part B Deductible means the deductible amount that
you are required to pay under Medicare Part B each calendar
year for Medicare Eligible Expenses.

Original Medicare Plan
The Original Medicare Plan means a fee-for-service health
plan that lets you go to any Physician, hospital, or other health
care supplier who accepts Medicare and is accepting new
Medicare patients. You must pay the deductible. Medicare
pays its share of the Medicare Approved Amount, and you pay
your share (coinsurance). In some cases you may be charged
more than the Medicare Approved Amount. The Original
Medicare Plan has Part A (Hospital Insurance) and Part B
(Medical Insurance).

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.

A Physician may be either a Participating Physician or Non-
Participating Physician. A Participating Physician is one who
has agreed in advance to accept Medicare assignments for
claims. The amount the Physician can charge is limited to the
Medicare Approved Amount. A non-Participating Physician
has not agreed to accept Medicare assignment and may charge
more than the Medicare Approved Amount.

Related Plan
The term Related Plan means the Policyholder’s employee
health plan.

Sickness
The term Sickness means a physical illness. This includes
mental illness and substance abuse.

Skilled Nursing Facility
The term Skilled Nursing Facility means a licensed institution
(other than a Hospital, as defined) which meets all of the
conditions required in order to be eligible for payment as a
skilled nursing facility under Medicare.

CIGNA HEALTH AND LIFE INSURANCE
COMPANY, a Cigna company (hereinafter called
Cigna)

Certificate Rider
You will become insured on the date you become eligible, if
you are in a class of Eligible Persons on that date.
This certificate rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified in the certificate.

The provisions set forth in this certificate rider comply with legislative requirements of Arizona. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

**Important Notice**

This notice is to advise you that you can obtain a replacement Appeals Process Information Packet by calling the Customer Service Department at the telephone number listed on your identification card for "Claim Questions/Eligibility Verification" or for "Customer Service" or by calling 1-800-244-6224.

The Information Packet includes a description and explanation of the appeal process for Cigna.

**Notice:** This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.

**The Schedule**

The schedule is amended to replace reference to Chiropractic Care Services with Spinal Manipulation and Subluxation Services which are covered the same as any other illness and are unlimited.

The following is added to the "Covered Expenses" section of your certificate:

- charges for Spinal Manipulation and Subluxation Services.

The following benefits will apply to insulin and noninsulin-dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- charges for Durable Medical Equipment, including glucagon emergency kits and podiatric appliances, related to diabetes. A special maximum will not apply.

- charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:

  - Medically Necessary visits when diabetes is diagnosed;
  - visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
  - visits when reeducation or refresher training is prescribed by the Physician; and
  - Medical Nutrition therapy related to diabetes management.

- 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 contraceptives, other than oral contraceptives.

- charges made in connection with mammograms for breast cancer screening performed on dedicated equipment for diagnostic purposes on referral by a patient's Physician, not fewer than: a baseline mammogram for women ages 35 to 39, inclusive; a mammogram for women ages 40 to 49, inclusive, every two years or more frequently based on the attending Physician's recommendation; or a mammogram every year for women age 50 and over.

- charges incurred at birth for the delivery of a child only to the extent that they exceed the birth mother's coverage, if any, provided: that child is legally adopted by you within one year from date of birth; you are legally obligated to pay the cost of the birth; you notify Cigna of the adoption within 60 days after approval of the adoption or a change in the insurance policies, plans or company; and you choose to file a claim for such expenses subject to all other terms of these Medical Benefits.

**Clinical Trials**

Charges made for routine patient services that are directly associated with participation in a cancer clinical trial approved by and being conducted at an Arizona institution. A cancer clinical trial is a course of treatment that is part of the scientific study to find treatment, palliation or prevention of cancer in humans, in which all of the following apply:

- the treatment is being provided as part of a study in a phase I, phase II, phase III or phase IV cancer clinical trial.
- there is no clearly superior, non-investigational treatment alternative.
- the clinical trial must be approved by at least one of the following:
  - One of the National Institutes of Health;
  - An NIH cooperative group or center;
  - The US FDA in the form of an investigational new drug application;
  - The US Department of Defense;
  - The US Department of Veterans Affairs;
  - A qualified research entity that meets the qualifications of the NIH for grant eligibility;
  - A panel of recognized experts within academic health institutions in AZ.
• services are performed by personnel acting within the scope of their practice, experience and training.

Routine patient services do not include, and reimbursement will not be provided for:
• any drug or device in a Phase I cancer trial;
• the investigational service or supply itself;
• managing the research of the clinical trial;
• treatment and services provided outside of Arizona;
• services or supplies listed herein as Exclusions;
• nonhealth services that might be required to receive treatment or intervention.

The following is added to your certificate:

Medical Benefits Extension

Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date, due to an Injury or Sickness, Medical Benefits will be paid for Covered Expenses incurred in connection with the Injury or Sickness. 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 Totally Disabled; or
• 12 months from the date your Medical Benefits cease due to cancellation of the policy; or
• 12 months 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 you or your Dependent's Medical Benefits cease.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or Sickness:
• you are unable to perform the basic duties of your occupation;
• you are not performing any other work or engaging in any other occupation for work or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or Sickness:
• he is unable to engage in the normal activities of a person of the same age, sex and ability; or
• in the case of a Dependent who normally works for wage or profit, he is not performing such work.

The definition of Dependent in the "Definitions" section of your certificate is amended as follows:

A child includes a legally adopted child who is entitled to Medicare by reason of disability, including that child from the first day of placement in your home regardless of whether the adoption has become final.

When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems. The following describes the process by which Members may obtain information and submit concerns regarding service, benefits, and coverage. For more information, see the Benefit Inquiry and Appeals Information Packet ("Appeal Packet"). Upon membership renewal or at any time thereafter, you may request an additional Appeal Packet by contacting Member Services at the toll-free number that appears on your Benefit Identification Card.

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, 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 Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

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

Appeals Procedure

Cigna has a two step appeals procedure for coverage decisions. To initiate an appeal, you can submit a request for an appeal by calling or writing us within two years of receipt of a denial notice, you can call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form, or you can write to us at the following address:

Cigna HealthCare Inc.
National Appeals Unit (NAU)
PO Box 188011
Chattanooga, TN 37422
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 the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

**Level One Appeal**

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

Within five working days after receiving your request for review, Cigna will mail you and your Primary Care Physician ("PCP") or treating Provider a notice indicating that your request was received, and a copy of the Appeal Packet (sent to PCP or treating Provider upon request). For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (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, your PCP or treating Physician certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

When an appeal is expedited, we will respond orally and in writing with a decision within the lesser of one working day or 72 hours.

**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. Please send your review request relating to denial of a requested service that has not already been provided within 365 days of the last denial. Your review requests relating to payment of a service already provided should be sent within two years of the last denial. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim.

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 a) not involved in any previous decision related to your appeal, and b) not a subordinate of previous decision makers. Provide all relevant documentation with your second-level appeal request.

For level two appeals we will acknowledge in writing that we have received your request within five working days after receiving your 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 and written notification of the decision will be completed within 30 calendar days. If more time or information is needed to make the preservice or concurrent care 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 us to complete the review.

You may request that the appeal process be expedited if, your Primary Care Physician or treating Physician certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services, or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

At any time during the appeal process Cigna has the option to request your appeal directly to External Independent Review without making a decision during the appeal process.

**External Independent Review**

**Eligibility**

Under Arizona law, a Member may seek an Expedited or Standard External Independent Review only after seeking any available Expedited Review, Level One Appeal, and Level Two Appeal. Your request for an Expedited or Standard External Independent Review should be submitted in writing.

**Deadlines Applicable to the Standard External Independent Review Process**

After receiving written notice from Cigna that your Level Two Appeal has been denied, you have 30 calendar days to submit a written request to Cigna for External Independent Review. Your request must include any material justification or documentation to support your request for the service or payment of a claim.

**Medical Necessity Issues**

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent...
reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review. If your appeal for External Independent Review involves an issue of medical necessity:

- Within five working days of receipt of your request for External Independent Review, Cigna will:
  - mail a written notice to you, your PCP or treating provider, and the Director of the Arizona Department of Insurance ("Director of Insurance") of your request for External Independent Review, and
  - send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.
- Within five days of receiving our information, the Insurance Director must send all submitted information to an external independent review organization (the "IRO").
- Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.
- Within five working days of receiving the IRO's decision, The Insurance Director must mail a notice of the decision to us, you, and your treating provider. If the IRO decides that Cigna should provide the service or pay the claim, Cigna must then authorize the service or pay the claim. If the IRO agrees with Cigna's decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Coverage Issues

These are cases where we have denied coverage because we believe the requested service is not covered under your certificate of coverage. For contract coverage cases, the Arizona Insurance Department is the independent reviewer. If your appeal for External Independent Review involves an issue of service of benefits coverage or a denied claim:

- Within five working days of receipt of your request for External Independent Review, Cigna will:
  - mail a written notice to you, your PCP or treating provider, and the Director of Insurance of your request for External Independent Review, and
  - send the Director of Insurance: your request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.
- Within 15 working days of the Director's receipt of your request for External Independent Review from Cigna, the Director of Insurance will:
  - determine whether the service or claim is covered, and
  - mail the decision to Cigna. If the Director decides that we should provide the service or pay the claim, we must do so.
  - If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have five working days after receiving the IRO's decision to send the decision to us, you, and your treating provider.
  - Cigna will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director of Insurance regardless of whether Cigna elects to seek judicial review of the decision made through the External Independent Review Process.
  - If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If Cigna disagrees with the Insurance Director's final decision, Cigna may also request a hearing before the OAH. A hearing must be requested within 30 calendar days of receiving the Insurance Director's decision.

Deadlines Applicable to the Expedited External Independent Review Process

After receiving written notice from Cigna that your Expedited Level Two Appeal has been denied, you have only five business days to submit a written request to Cigna for an Expedited External Independent Review. Your request must include any material justification or documentation to support your request for the service or payment of a claim.

Medical Necessity Issues

If your appeal for Expedited External Independent Review involves an issue of medical necessity:

- Within one working day of receipt of your request for an Expedited External Independent Review, Cigna will:
  - mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and
• forward to the Director your request for Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of Cigna's decision, the criteria used and the clinical reasons for the decision, relevant portions of Cigna's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.

• Within two working days after the Director receives the information outlined above, the Director will choose an independent review organization (IRO) and forward to the organization all of the information received by the Director.

• Within five working days of receiving a case for Expedited External Independent Review from the Director, the IRO will evaluate and analyze the case and based on all the information received, render a decision and send the decision to the Director. Within one working day after receiving a notice of the decision from the IRO, the Director will mail a notice of the decision to you, your PCP or treating provider, and Cigna.

Coverage Issues
If your appeal for Expedited External Independent Review involves a contract coverage issue:

• Within one working day of receipt of your request for an Expedited External Independent Review, Cigna will:
  • mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and
  • forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of Cigna's decision, the criteria used and the clinical reasons for the decision, relevant portions of Cigna's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.

• Within two working days after receipt of all the information outlined above, the Director will determine if the service or claim is covered and mail a notice of the determination to you, your PCP or treating provider, and Cigna.

• If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have five working days to make a decision and send it to the Director. The Director will have one working day after receiving the IRO's decision to send the decision to Cigna, you and your treating provider.

• Cigna will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director regardless of whether Cigna elects to seek judicial review of the decision made through the External Independent Review Process.

• If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If Cigna disagrees with the Director's final decision, Cigna may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision.

The Independent Review Program is a voluntary program arranged by Cigna.

Under Arizona law, if you intend to file suit regarding a denial of benefit claim or services you believe are medically necessary, you are required to provide written notice to Cigna at least 30 days before filing the suit stating your intention to file suit and the basis of your suit. You must include in your notice the following:

  Member Name
  Member Identification Number
  Member Date of Birth
  Basis of Suit (reasons, facts, date(s) of treatment or request)

Notice will be considered provided by you on the date received by Cigna. The notice of intent to file suit must be sent to Cigna via Certified Mail Return Receipt Request to the following address:

  Attention: HealthCare Litigation Unit B6LPA
  Notice of Intent to File Suit
  Cigna Health and Life Insurance Company
  900 Cottage Grove Road
  Hartford, CT 06152

Receipt of Documents
Any written notice, acknowledgment, request, decision or other written documents required to be mailed during the process is deemed received by the person to whom the document is properly addressed on the fifth working day after being mailed. "Properly addressed" means your last known address.

Complaints to the Arizona Department of Insurance
The Director of the Arizona Department of Insurance is required by law to require any Member who files a complaint with the Arizona Department of Insurance relating to an adverse decision to first pursue the review process established by the Arizona Legislature and Cigna as described above.
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: 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 under ERISA section 502(a); 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.

You also have the right to bring a civil action under Section 502(a) of ERISA 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. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

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.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level-One and Level-Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.