

SCHOOLCARE

HEALTH BENEFIT PLANS

of the NEW HAMPSHIRE SCHOOL HEALTH CARE COALITION



Health Benefits Booklet
HMO, POS Open Access, Open Access +

**SCHOOLCARE
Health Benefits Booklet**

Table of Contents

Section	Page
1. INTRODUCTION	2
2. DEFINITIONS	2
3. SCHEDULES OF BENEFITS	
HMO (Health Maintenance Organization)	10
POS (Point of Service, Open Access)	17
OPEN ACCESS +	26
4. BENEFITS AND SERVICES (additional information)	
A. Outpatient Services	33
B. Inpatient Services	34
C. Ambulance Services	35
D. Breast Reconstruction and Breast Prosthesis	35
E. Dialysis	35
F. Emergency Services	35
G. Home Health Services	35
H. Organ Transplants and Related Services	36
I. Mental Health and Substance Abuse Services	37
J. Clinical Trials	38
K. Prescription Drug Benefit	38
L. Nutritional Formulas	42
M. Durable Medical Equipment	42
N. External Prosthetic Appliances	43
5. EXCLUSIONS AND LIMITATIONS	44
6. ELIGIBILITY AND ENROLLMENT	47
7. PAYMENT FOR COVERAGE	51
8. TERM AND TERMINATION	51
9. CONTINUATION OF COVERAGE	52
10. SUBROGATION, REIMBURSEMENT AND RIGHT OF RECOVERY	55
11. COORDINATION OF BENEFITS (COB)	57
12. CLAIMS PROCEDURES	60
13. APPEAL PROCEDURES	60
14. CIGNA HEALTHCARE CONFIDENTIALITY POLICIES	63
15. SCHOOLCARE NOTICE OF PRIVACY PRACTICES	65
16. MISCELLANEOUS PROVISIONS	68

1. INTRODUCTION

The benefits described in this booklet, or any endorsements and riders attached hereto, are self-insured by the New Hampshire School Health Care Coalition (the Coalition), which is responsible for paying claims. Connecticut General (also referred to as CG) provides claim administration services to the Coalition, but does not insure the benefits described herein.

This Health Benefits Booklet, any endorsements or riders, the Schedule of Benefits, the Enrollment Application and the material accompanying the Identification Cards, constitute the agreement between the Coalition and the Subscriber and all enrolled family Dependents. After a Subscriber's Enrollment Application is accepted by the Coalition and CG, the Subscriber and any enrolled family Dependents named on the Enrollment Application are entitled to receive the benefits described in this Health Benefits Booklet.

Covered Services are subject to all the terms, conditions, limits and exclusions contained in this Health Benefits Booklet, any endorsements or riders, the Schedule of Benefits, the Enrollment Application and the Identification Card. Any Member who obtains Covered Services will be deemed to have read this Health Benefits Booklet and agreed to all its provisions.

2. DEFINITIONS

CIGNA HealthCare. CIGNA HealthCare refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, CIGNA Vision Care, Inc., Tel-Drug, Inc., and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. CIGNA Tel-Drug refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C., which are also operating subsidiaries of CIGNA Corporation.

Coinsurance. Coinsurance is the specified percentage of the charges that the Member and the Coalition pay for covered services. Refer to the Schedule of Benefits, any endorsements or riders for Coinsurance percentages.

Connecticut General (CG). Connecticut General Life Insurance Company. The company that provides medical claims administration services for the New Hampshire School Health Care Coalition.

Contract Year. The Contract Year is July 1 through June 30. Benefits that are subject to annual limitations are calculated according to the Contract Year.

Copay. The dollar amount, which is required to be paid by the Member for certain Covered Services. Please refer to the Schedule of Benefits and any endorsements or riders for the Copay amounts. Copays will be collected by Participating Providers at the time Covered Services are rendered.

Cosmetic Services. Surgery or other services, drugs or devices performed to improve or alter appearance or self-esteem or to treat psychological, symptomatology or psychosocial complaints related to one's appearance, and which are not principally intended to affect the physical functioning of the body or to functionally reconstruct a portion of the body after a trauma, surgery, infection or other disease. Cosmetic Services include, but are not limited to, removal of tattoos and non-cancerous skin tags, moles, warts, facelifts, rhinoplasty, blepharoplasty, keloid removal, augmentation or reduction mammoplasty.

Covered Services. The benefits and services listed in Sections 3 and 4 (including any endorsements or riders). Covered Services are subject to all conditions, limitations and exclusions set forth in Sections 3, 4 and 5 of this Health Benefits Booklet (including any endorsements or riders).

Custodial/Convalescent Care. Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This includes care primarily to help the person in activities of daily living and medical services to maintain the person's current state of health when no other aspects of treatment require an acute Hospital level of care. These services cannot be intended to greatly improve a medical condition. They are intended to provide care while the patient cannot care for himself or herself. Custodial Services include, but are not limited to,

- (1) services related to watching or protecting a person;
- (2) services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in and out of bed, toileting, eating, preparing food, or taking medications that can be self-administered,
- (3) routine maintenance of colostomies, ileostomies and urinary catheters, or
- (4) services not required to be performed by trained and skilled medical or paramedical personnel.

Deductible. The amount you must pay toward Covered Services in each Contract Year before the Coalition begins paying its share of covered expenses. Refer to the Schedule of Benefits, and any endorsements or riders for Deductible amounts.

Dependents. Members of a Subscriber's family who are eligible to enroll in **SCHOOLCARE**. To be eligible for Covered Services, they must be enrolled in **SCHOOLCARE** by listing them on the Enrollment Application. Newborns are automatically covered during the first 30 days of life. Continuation of coverage beyond 30 days will require that the Premium be retroactively applied to the date of birth. Newborns must be added within this 30-day period. Dependents include:

- (1) The spouse to whom the Subscriber is legally married; or,
- (2) The Subscriber's partner in a valid New Hampshire civil union or in a civil union recognized by the state of New Hampshire.
- (3) The Subscriber's child by blood or by law under the age of twenty-six (26) who
 - is unmarried and
 - is a resident of New Hampshire or a student at a public or private institution of higher learning; and
 - who is not provided coverage as a named subscriber, insured, enrollee or covered person under any group or individual health plan, or entitled to benefits under Title XVIII of the Social Security Act, Public Law 89-97, 42 U.S. C. 1395 et seq; or,
- (4) A Dependent qualified as a part-time or full-time student under (3)(b) above and on a medically necessary leave of absence from a public or private institution of higher learning for a period not to exceed the earlier of twelve (12) months or the end of the month following the Dependent's twenty-sixth (26th) birthday. Documentation and certification of the medical necessity for the leave of absence must be submitted to the Coalition by the Dependent's attending physician, and shall be considered prima facie evidence of entitlement to coverage under this subparagraph. The date of the documentation and certification of the medical leave of absence shall be the date eligibility commences under this subparagraph; or,
- (5) Any individual nineteen (19) or more years of age and continuously incapable of self-sustaining support because of a mental or physical handicap which existed prior to attaining age 19, provided that the disabled Dependent was covered by **SCHOOLCARE** at the time such coverage would have ended, and there has been no lapse of coverage. You must submit proof of the child's condition and dependence to CG within 30 days after the date the child ceases to qualify as a Dependent under the subsections listed above. CG may, from time to time, during the next two years require proof of the

continuation of the child's condition and dependence. Thereafter, CG may require such proof only once a year. Upon failure to submit required proof or when the child is no longer incapacitated, coverage with respect to the child shall cease.

The term child as used above includes the Subscriber's own child by natural birth; a child that is placed for adoption with the Subscriber; or a stepchild or foster child who lives with the Subscriber. The term child excludes anyone who is enrolled for coverage as a Subscriber or enrolled for coverage as an employee under another health benefit plan. Benefits for a Dependent child or student will continue until the last day of the calendar month in which the limiting age is reached. Anyone who is an Eligible Employee will not be considered a Dependent. No one may be considered as a Dependent of more than one Eligible Employee. Coverage is not provided for a newborn child of a Dependent, unless the Subscriber becomes the legal guardian of the child or legally adopts the child. For more information on Dependents, see Section 6.

Eligible Employee(s). That person or those persons designated by the employer and the Coalition as being eligible to enroll as Subscribers.

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

Enrollment Application. A form that must be completed by each person interested in becoming a Subscriber. By signing the Enrollment Application or applying for membership in the **SCHOOLCARE** program, the Subscriber and enrolled Dependents agree to abide by the terms and conditions of this Health Benefits Booklet. Members also agree that CG may obtain from health care providers such medical records and other patient information as CG deems necessary to administer **SCHOOLCARE** benefits, respond to audits by government agencies, and public or private accreditation agencies. CG abides by all Federal and State laws governing the privacy of medical information.

Experimental, Investigational or Unproven Services. Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by CG to be:

- (1) Not approved by the U.S. Food and Drug Administration ("FDA") or other appropriate regulatory agency to be lawfully marketed for the proposed use; or
- (2) Subject to review and approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials for Treatment Studies on Cancer and Life-Threatening Conditions" set forth in Section 4.J.; or
- (3) The subject of an ongoing clinical trial that meets the definition of Phase I, II or III clinical trial set forth in the FDA regulations regardless of whether the trial is subject to FDA oversight; (except as set forth in the Section 4.J.); or
- (4) Not demonstrated through existing peer-reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Formulary. A listing of approved Prescription Drugs and related supplies. The Prescription Drugs and related supplies included in the Formulary have been approved in accordance with parameters established by the Pharmacy and Therapeutics (P&T) Committee. The Formulary is regularly reviewed and updated by the P&T Committee and subject to change at any time without notice.

Health Benefits Booklet. This description of Covered Services, exclusions, limitations, requirements, for membership, supplemental agreements, endorsements, or riders, and the Schedule of Benefits.

Hospice Care Program. A coordinated, licensed, interdisciplinary program to meet the physical, psychological, spiritual and social needs of a terminally ill person who has a life expectancy of less than six months. Hospice Care is provided to terminally ill patients in their home on an outpatient basis, or on a short-term inpatient basis when, for medical reasons, the control of pain and management of acute and severe clinical problems cannot be managed in a home setting. The following are Covered Services:

- (1) Room and board at a licensed Hospice facility;
- (2) Medically Necessary services and supplies for the patient's care;
- (3) Physician services, nursing care by (or supervised by) a registered graduate nurse;
- (4) Home health care services; and
- (5) Palliative care.

Hospital. An institution, which operates as a Hospital pursuant to law, primarily for reception, care and treatment of sick or injured persons.

- (1) A Hospital means a licensed institution that 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.
- (2) 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 Health Care Organizations; or,
- (3) An institution that (a) specializes in treatment of mental health and substance abuse or other related illness; and (b) is licensed in accordance with the laws of the appropriate legally authorized agency.

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

Identification Card. A card issued to all Members upon approval of an Enrollment Application by CG and the Coalition. Members must show their Identification Cards to Participating Providers in order to receive medical services. By using the Identification Card to obtain Covered Services, the Member agrees to all terms and conditions on the Enrollment Application and in this Health Benefits Booklet, including allowing CG access to medical records for utilization management and quality assurance purposes, and to coordinate benefits.

Maintenance Treatment. The term Maintenance Treatment means routine, long-term, or non-medically necessary care provided to prevent recurrences or to maintain a patient's current status, or is provided after the resolution of an acute medical problem when significant therapeutic improvement is not expected.

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

Medically Appropriate. A health care service is Medically Appropriate when:

- (1) The expected health benefit from a medical service is clinically significant and significantly exceeds the anticipated health risk;
- (2) The health care service is considered by CG's Physician Reviewer to be of clinical value and represents a superior service compared to other medical services (including no medical services);
- (3) The potential benefit from the health care service may include, but is not limited to, improved functional capacity; prevention of complications; or palliative relief.

Medically Necessary/Medical Necessity. Health care services and supplies that are determined by CG's Physician Reviewer or by employees or third parties designated by the CG to be:

- (1) Medically Appropriate to meet the essential health needs of the Member;
- (2) Consistent with the diagnosis of the condition;
- (3) Consistent in type, frequency, and duration of treatment with scientifically-based guidelines as determined by medical research;
- (4) Required for purposes other than the comfort and convenience of the patient, the Physician or other health care provider;
- (5) Rendered in the least-intensive setting that is appropriate for the delivery of health care; and
- (6) Of a demonstrated medical value. In making this determination, CG's Physician Reviewer may refer to, among other things, guidelines and/or protocols developed by CG and/or third parties.

Note: Regardless of whether services may be Medically Necessary, certain benefits have limits, such as the number of visits, inpatient days or dollar caps; or may not be a Covered Service under the provisions of this Health Benefits Booklet, including any endorsements or riders.

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

Member. An individual who meets the eligibility criteria as a Subscriber or Dependent and is enrolled in **SCHOOLCARE**, and for whom all required Premiums have been paid.

Mental Health Referral Organization. An organization which is under contract with CG to provide management and utilization review of providers rendering mental health and substance abuse Covered Services.

New Hampshire School Health Care Coalition (the Coalition). The organization which contracts with an employer to provide health benefits under the **SCHOOLCARE** program, subject to the terms and conditions of the agreement between the Coalition and the employer.

Non-Participating Provider. A health care professional or institution that has not contracted with CG to provide Covered Services to Members.

Open Enrollment Period. The period established by the Coalition during which Eligible Employees and their Dependents may enroll in the **SCHOOLCARE** program. The Open Enrollment Period occurs at least once a year. Other than during the Open Enrollment Period, you or your Dependents cannot enroll in **SCHOOLCARE** or change the type or level of coverage, except as provided in Section 6. B. (Enrollment) of this Health Benefits Booklet.

Other Health Care Facility. A facility other than a Hospital. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing Facilities, rehabilitation Hospitals and sub-acute facilities.

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

Outpatient Surgical Facility/Ambulatory Surgical Center. A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing outpatient surgical procedures and meets applicable licensing and other requirements.

Participating Pharmacy. A retail or mail order pharmacy contracted with CIGNA HealthCare to provide Prescription Drug benefits to **SCHOOLCARE** Members.

Participating Provider. A Health Care Professional, facility or institution, which is under contract with CG, including but not limited to Physicians, nurses, mental health professionals and Hospitals. The relationship between CG and the provider is a contractual relationship between independent contractors. Each provider must be licensed or certified by the state in which services are rendered and acting within the scope of his/her license.

Pharmacy & Therapeutics (P&T) Committee. A committee of Participating Providers, pharmacists, Physician Reviewers and pharmacy directors, which regularly reviews Prescription Drugs and related supplies for safety, efficacy, cost effectiveness and value. The P&T Committee evaluates Prescription Drugs and related supplies for addition to or deletion from the Formulary and may also set dosage and/or dispensing limits on Prescription Drugs and related supplies.

Physician. An individual who is qualified to practice medicine under applicable state law (or a partnership of professional association of such people) and who is a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Physician Reviewer. A Physician designated by CG to review, approve or otherwise determine if services are Medically Appropriate, Necessary and a Covered Service.

Premium. The prepaid amount charged by the Coalition for the services and benefits provided under this Health Benefits Booklet.

Prescription Drug. A medication, product or device that has been approved by the Food & Drug Administration and that can be dispensed under federal and state law only with a prescription order or refill.

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

Preventive Services or Care. Includes services provided to Members for the purpose of promoting health and preventing illness or injury. CIGNA HealthCare follows guidelines and recommendations from various nationally recognized organizations, such as the U.S. Preventive Services Task Force and the American Academy of Pediatrics. Preventive Care does not include monitoring, counseling, diagnostic testing and other interventions provided to patients with symptoms or established illness.

Primary Care Physician (PCP). A Physician, through an agreement with CG that practices general medicine, family medicine, internal medicine or pediatrics. A PCP may also arrange or refer patients for specialized services.

Prior Approval (also Prior Authorization or Pre-Certification). Depending on the SCHOOLCARE benefits you select, Prior Approval may be required before certain services are covered:

- (1) By the PCP for Referral to another Participating Provider for Medically Necessary Covered Services; or,
- (2) By CG and the Primary Care Provider, in writing, to a Non-Participating Provider for Medically Necessary Covered Services; or,
- (3) By CG and the Participating Provider, in writing, for coverage of certain benefits and services as stated in this Health Benefits Booklet, including any endorsements or riders.

Note: It is the member's responsibility to obtain Prior Approval for certain Covered Services rendered by a Non-Participating Provider. Examples of services that require Prior Authorization include, but are not limited to inpatient Hospital services, inpatient services at any Other Health Care Facility, certain Outpatient Facility services, magnetic resonance imaging (MRI) and organ transplant services. If a Member's coverage is terminated prior to the date of service, the service will not be covered, regardless of any Prior Approval given by CG.

Qualifying Event. All changes in membership must be submitted in writing to your employer and the Coalition. Additions and/or deletions of Dependent Members must be made within 30 days following a Qualifying Event, which includes:

- (1) Marriage and/or divorce,
- (2) Civil union and/or dissolution of a civil union (in accordance with NH law),
- (3) Birth and/or death,
- (4) Adoption of a child,
- (5) Addition of stepchildren,
- (6) Permanent legal custody of a child,
- (7) Reinstatement of civilian status from active military personnel or
- (8) When a Member ceases to be a Dependent as defined above.

Subject to Premiums being paid to the Coalition, coverage will take effect on the date of the Qualifying Event. If your employer and the Coalition are not notified within 30 days of the Qualifying Event, membership type cannot be changed until the next Open Enrollment Period.

Reasonable and Customary. Expenses are Reasonable and Customary to the extent they do not exceed an amount based on the lesser of:

- (1) The provider's usual charge for a Covered Service, treatment or related supplies; or,
- (2) The prevailing charge for a Covered Service, treatment or related supplies made by other providers in the same geographic area where the service is received, as determined by CG; or,
- (3) The amount allowed under a CG provider's contract for the Covered Services, treatment or related supplies.

Referral. Depending on the SCHOOLCARE benefits you select, an authorization from the Member's PCP to another Participating Provider for Medically Necessary Covered Services. See the Schedule of Benefits.

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

Review Organization. The term Review Organization refers to an affiliate of CG or another entity to which CG has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians, which may include

Physicians, registered graduate nurses, licensed mental health and substance abuse professionals, and other trained staff who perform utilization review services.

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

Schedule of Benefits. A table or chart outlining **SCHOOLCARE** benefits, and certain exclusions (by way of example). There are separate Schedules of Benefits for the HMO, the POS, Open Access and the Open Access + benefit plans.

SCHOOLCARE. Health Benefits offered by the New Hampshire School Health Care Coalition.

Short-Term Rehabilitation Services. Those diagnostic and therapeutic services designed to restore or replace functional capabilities. This includes: physical therapy, occupational therapy, speech therapy, manipulation therapy, cardiac rehabilitation and pulmonary rehabilitation. In order to be covered by **SCHOOLCARE**, CG must determine that your condition is subject to significant improvement as a direct result of the Short-Term Rehabilitative therapy, and provided in the most Medically Appropriate setting.

Skilled Nursing Facility. The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which operates pursuant to law and specializes in physical rehabilitation on an inpatient basis, or skilled nursing and medical care on an inpatient basis, but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment for compensation under the supervision of Physicians; and (c) provides skilled nursing services.

Subscriber. An Eligible Employee whose Enrollment Application has been accepted by CG and the Coalition, and for whom all required Premiums have been paid.

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

3. Schedules of Benefits

HMO Schedule of Benefits

Covered Services in the HMO plan must be rendered or authorized by your Primary Care Physician, and/or authorized by CIGNA HealthCare. As an HMO Member, you must use Participating Providers in the CIGNA network to receive benefits. However, you do not need a referral from your Primary Care Physician to access the following services:

- Emergency care;
- Outpatient services for mental health and substance abuse;
- Routine OB/GYN exam;
- Chiropractic care;
- Acupuncture; and,
- Routine vision care.

These services are covered without a Referral, but you must use Participating Providers (except in cases of Emergency or for acupuncture services).

The following chart is a Schedule of Benefits for the HMO plan.

Schedule of Benefits
SCHOOLCARE
HMO

BENEFIT HIGHLIGHTS		IN-NETWORK	
<i>Lifetime Maximum</i>		Unlimited	
		YOU PAY	
Preventive Care			
<i>Routine Preventive Care - Adult, Well-Baby, Well-Child.</i>		No charge after \$10 office visit Copay	
<i>Annual OB/GYN Exam (no Referral necessary)</i>			
<i>Immunizations</i>		No charge	
<i>Routine Mammograms, PSA, PAP Smear</i>		No charge	
<i>Routine Vision Care</i>		Note: The associated wellness exam is subject to the office visit Copay.	
<i>Eye Exam every 12 months (no Referral necessary)</i>		No charge after \$10 office visit Copay	
<i>Eye Glasses/Contact Lenses not covered</i>			
Physician's Services			
<i>Primary Care Physician's Office Visit</i>		No charge after \$10 office visit Copay	
<i>Specialty Care Physician's Office Visit</i>		No charge after \$10 office visit Copay	
<i>Office Visits</i>			
<i>Consultant and Referral Physician's Services</i>			
<i>Surgery Performed In the Physician's Office</i>		No charge after \$10 office visit Copay	
<i>Allergy Treatment/Injections</i>		No charge after either the office visit Copay or the actual charge, whichever is less	
<i>Allergy Serum (dispensed by the physician in the office)</i>		No charge	
Routine Foot Care		Not covered, except for services associated with care of diabetes and peripheral vascular disease, when Medically Necessary	
Hearing Test <i>(covered under PCP to age 19)</i>		No charge after \$10 office visit Copay	
Laboratory and Radiology Services		No charge	
Outpatient Pre-Admission Testing			
<i>Primary Care Physician's Office Visit</i>		No charge if only x-ray and/or lab services; \$10 office visit Copay if other office visit services also provided	
<i>Specialist Physician's Office Visit</i>		No charge if only x-ray and/or lab services; specialist \$10 office visit Copay if other office visit services also provided	
<i>Outpatient Facility</i>		No charge	
<i>Independent X-ray and/or Lab Facility</i>		No charge	
Outpatient Facility Services		No charge	
<i>Operating Room, Recovery Room, Procedure Room and Treatment Room</i>			
Outpatient Professional Services		No charge	
<i>Surgeon, Radiologist, Pathologist, Anesthesiologist</i>			
Inpatient Hospital - Facility Services		No charge	
<i>Semi-Private Room and Board</i>			
Inpatient Hospital Physician's Visits/Consultations		No charge	

BENEFIT HIGHLIGHTS	IN-NETWORK
Inpatient Hospital Professional Services <i>Surgeon, Radiologist, Pathologist, Anesthesiologist</i>	No charge
Inpatient Services at Other Health Care Facilities <i>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</i> <i>100 days combined maximum per Contract Year</i> <i>No prior hospitalization required.</i>	No charge
Emergency and Urgent Care Services <i>Physician's Office</i> <i>Hospital Emergency Room</i> <i>Urgent Care Facility or Outpatient Facility</i> <i>Ambulance</i>	No charge after \$10 office visit Copay No charge after \$50 per visit Copay* (Copay waived if admitted) No charge after \$25 per visit Copay No charge* * If not a true Emergency, services are not covered
Outpatient Short-Term Rehabilitative Therapy <i>60 visits combined maximum per Contract Year</i> <i>Includes:</i> <i>Cardiac Rehab</i> <i>Physical Therapy</i> <i>Speech Therapy</i> <i>Occupational Therapy</i> <i>Pulmonary Therapy</i>	No charge after \$10 visit Copay Note: Therapy, as part of a CG approved Home Health Care plan, accumulates to the Outpatient Short-Term Rehabilitative maximum
Chiropractic Therapy <i>20 visits per Contract Year (no Referral necessary)</i>	No charge after \$10 office visit Copay
Acupuncture* <i>12 visits per Contract Year (no Referral necessary)</i> <i>*Subject to CIGNA HealthCare Guidelines. See Section 4.A.</i>	\$10 office visit Copay
Home Health Care <i>(includes outpatient private duty nursing when approved by CG as Medically Necessary)</i>	No charge <i>Note: The maximum number of hours per day is limited to 16. Multiple visits can occur in one day, with a visit defined as a period of two hours or less (maximum of eight visits per day).</i>
Hospice <i>Inpatient Services</i> <i>Outpatient Services</i>	No charge No charge
Maternity Care Services <i>Initial Visit to Confirm Pregnancy</i> <i>All subsequent Prenatal Visits, Postnatal Visits and Delivery</i> <i>Delivery (Inpatient Hospital, Birthing Center)</i>	No charge after \$10 office visit Copay No charge No charge
Abortion <i>Includes elective and non-elective procedures</i> <i>Office Visit</i> <i>Inpatient Facility</i> <i>Outpatient Surgical Facility</i> <i>Physician's Services</i>	No charge after \$10 office visit Copay No charge No charge No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Family Planning Services <i>Office Visit (tests, counseling)</i> <i>Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)</i> <i>Inpatient Facility</i> <i>Outpatient Facility</i> <i>Physician's Services</i></p>	<p>No charge after \$10 office visit Copay</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>
<p>Infertility Treatment <i>Coverage will be provided for the following services:</i> <i>Testing and treatment services performed in connection with an underlying medical condition;</i> <i>Testing performed specifically to determine the cause of infertility;</i> <i>Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition);</i> <i>Artificial Insemination.</i></p> <p><i>Office Visit (Test, Counseling)</i> <i>Inpatient Facility</i> <i>Outpatient Facility</i> <i>Services not covered include, but are not limited to, In-vitro, GIFT, ZIFT, and Infertility Drugs.</i></p>	<p>No charge after specialist \$10 office visit Copay</p> <p>No charge</p> <p>No charge</p>
<p>Organ Transplants <i>Includes all medically appropriate, non-experimental transplants</i> <i>Office Visit</i> <i>Inpatient Facility</i> <i>Inpatient Physician's Services</i> <i>Travel Maximum</i></p>	<p>Benefits provided through the CIGNA LIFESOURCE Organ Transplant Network</p> <p>No charge after specialist \$10 office visit Copay</p> <p>No charge</p> <p>No charge</p> <p>\$10,000 per transplant/per lifetime maximum (only available when using a CIGNA LIFESOURCE facility)</p>
<p>Durable Medical Equipment (DME)</p>	<p>\$5,000 per person, per Contract Year (unlimited for post mastectomy breast reconstruction and breast prosthesis)</p> <p>Member Coinsurance of 20%</p>
<p>External Prosthetic Appliances</p>	<p>\$10,000 per person, per Contract Year (unlimited for post-mastectomy breast reconstruction and breast prosthesis)</p> <p>Member Coinsurance of 20%</p>
<p>Dental Care <i>Charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.</i> <i>Removal of boney impacted wisdom teeth.</i> <i>Physician's Office</i> <i>Inpatient Facility</i> <i>Outpatient surgical Facility</i> <i>Physician's Services</i></p>	<p>(Prior-authorization Required for Dental Care)</p> <p>No charge after \$10 office visit Copay</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>

BENEFIT HIGHLIGHTS	IN-NETWORK
Prescription Drugs <i>CIGNA Pharmacy Retail Drug Program</i> <i>Includes oral contraceptives and contraceptive devices</i>	\$5 per 30-day supply for generic drugs \$15 per 30-day supply for preferred brand name drugs \$35 per 30-day supply for non-preferred brand name drugs
CIGNA Tel-Drug Mail Order Drug Program <i>Mandatory Mail Order Program</i> <i>Includes oral contraceptives and contraceptive devices</i>	\$5 per 90-day supply for generic drugs \$15 per 90-day supply for preferred brand name drugs \$35 per 90-day supply for non-preferred brand name drugs
Mental Health/ Substance Abuse <i>Inpatient Hospitalization</i> <i>Outpatient</i>	No charge, no referral required No charge after \$10 office visit Copay
Pre-Existing Condition Limitation	Not Applicable
Pre-Admission Certification-Continued Stay Review required for all Inpatient Admissions	Coordinated by Participating Provider, PCP and CG
Prior Authorization required for selected outpatient procedures and diagnostic testing	Coordinated by Participating Provider, PCP and CG
Case Management	Coordinated by CG. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.

Benefit Exclusions

Your HMO provides coverage for Medically Necessary services rendered or authorized by your PCP and/or authorized by CG.

It does not provide coverage for the following (by way of example, but not limited to):

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury, which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Health Benefits Booklet.
6. Assistance in the activities of daily living including, but not limited to, eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the CG Physician Reviewer to be: not demonstrated through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" Section 4. J.

8. Cosmetic Services, including 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.
9. The following services are excluded from coverage regardless of clinical indications: acupressure, macromastia or gynecomastia surgery, rhinoplasty, blepharoplasty, redundant skin surgery, removal of skin tags, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing; prolotherapy, and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
10. Treatment of TMJ disorder. But see Section 5. B. (3) of this Health Benefits Booklet.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth including, but not limited to, dental x-rays, examinations, repairs, extractions, orthodontics, dental implants, periodontics, casts, splints and services for dental malocclusion for any condition. Exceptions: Removal of boney impacted wisdom teeth is a Covered Service. Also, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% boney support and are functional in the arch. Dental implants are not covered for any condition.
12. 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.
13. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician and approved by CG.
14. Infertility drugs, in vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm. Cryopreservation of donor sperm and eggs are also excluded.
15. Reversal of male and female voluntary sterilization procedures.
16. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
17. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction including, but not limited to, anorgasmia, erectile dysfunction and premature ejaculation. However, penile implants and certain medications may be covered, subject to Medical Necessity and CG approval.
18. Medical and Hospital care and costs for the infant child of a Dependent.
19. Non-medical counseling or ancillary services including, but not limited to, Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities or developmental delays, autism or mental retardation.
20. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance including, but not limited, to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
21. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited, to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in Section 4 of this Health Benefits Booklet.
22. Private hospital rooms and/or private duty nursing unless approved by the CG Physician Reviewer.
23. 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 illness or injury.
24. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, garter belts, corsets and dentures.
25. Hearing aids including, but not limited to, semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound. But see section 4. M. (coverage for children under age 19).
26. Aids or devices that assist with non-verbal communications including, but not limited to, communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
27. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).

28. Eye exercises and surgical treatment for the correction of refractive errors including radial keratotomy, conductive keratoplasty and related procedures.
29. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
30. Orthotic devices, except as otherwise noted in Section 4. N.
31. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
32. Ultrasound or any other procedures requested solely for sex determination of the fetus.
33. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
34. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where, in the CG Physician Reviewer's opinion, the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
35. Blood administration for the purpose of general improvement in physical condition.
36. The cost of biologicals that are immunizations or medications, and all other medical services required for the purpose of travel, employment or by other third parties, including protection against occupational hazards and risks.
37. Cosmetics, dietary supplements and health and beauty aids.
38. Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan. See Section 11, Coordination of Benefits.
39. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
40. Charges in excess of Reasonable and Customary.
41. Massage Therapy.

This Schedule highlights the benefits available under the HMO plan. Further details regarding the terms of coverage, exclusions and limitations are included in this Health Benefits Booklet.

Benefits administered by Connecticut General Life Insurance Company.

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, CIGNA Vision Care, Inc., Tel-Drug, Inc., and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. "CIGNA Tel-Drug" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C., which are also operating subsidiaries of CIGNA Corporation.

POS Open Access Schedule of Benefits

In the POS Open Access plan you do not need to select a Primary Care Physician.* You do not need Referrals to see other doctors. However, you will receive a higher level of benefits if you use CIGNA Participating Providers. If you use Providers not part of the CIGNA network, you must first pay the Contract Year Deductible and then 20% Coinsurance until you meet the out of pocket maximum for the Contract Year. Reimbursement for Non-Participating Providers is subject to Reasonable and Customary charges. You are responsible for any charges above Reasonable and Customary, and these excess charges will not count toward meeting your out-of-pocket maximum for the Contract Year. If you use Non-Participating Providers, you are responsible for obtaining Pre-Certification, Prior Approval or Authorization from CG for certain outpatient services and inpatient admissions. Some benefits are covered only in-network. These include:

- Routine Preventive Care;
- Organ Transplants;
- Routine Vision Care;
- Hearing Test (covered under PCP to age 19); and
- Pharmacy Benefits

. The following chart is a Schedule of Benefits for the POS Open Access plan.

**While not required to select a Primary Care Physician (PCP), Members are encouraged to establish and maintain a relationship with a PCP to meet preventive and basic health care needs. Also, a Primary Care Physician may be helpful in coordinating your care and initially arranging referrals to specialists.*

Schedule of Benefits
SCHOOLCARE
POS Open Access

BENEFIT HIGHLIGHTS	IN-NETWORK No Referrals Necessary	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	\$1,000,000
Contract Year Deductible		
<i>Individual</i>	None	\$300 per person
<i>Family Maximum</i>	None	\$600 per family
<i>Aggregate</i>	No	Yes
Coinsurance	For Durable Medical Equipment and External Prosthetic Appliances (20%)	20%
Out-of-Pocket Maximum		
<i>Includes Coinsurance</i>	Not Applicable	Yes
<i>Includes Deductible</i>	Not Applicable	Yes
<i>Individual</i>	Not Applicable	\$900 per person
<i>Family Maximum</i>	Not Applicable	\$1,800 per family
<i>Aggregate Does Not Apply To</i>	Not Applicable	Non-compliance penalties or charges in excess of Reasonable and Customary Charges
	YOU PAY	YOU PAY
Preventive Care		
<i>Routine Preventive Care: Adult, Well-Baby, Well-Child,</i>	No charge after \$10 office visit Copay	In-network coverage only
<i>Annual OB/GYN Exam</i>	No charge after \$10 office visit Copay	Deductible, then 20% to Out-of-Pocket Maximum
<i>Immunizations</i>	No charge	Deductible, then 20% to Out-of-Pocket Maximum
<i>Routine Mammograms, PSA, PAP Smear</i>	No charge Note: The associated wellness exam is subject to the office visit Copay.	Deductible, then 20% to Out-of-Pocket Maximum
<i>Routine Vision Care</i>	No charge after \$10 office visit Copay	In-network coverage only
<i>Eye Exam every 12 months</i>		
<i>Eye Glasses/Contact Lenses Not Covered</i>		

BENEFIT HIGHLIGHTS	IN-NETWORK No Referrals Necessary	OUT-OF-NETWORK
Physician's Services <i>Primary Care Physician's Office visit</i> <i>Specialty Care Physician's Office Visit</i> <i>Office Visits</i> <i>Consultant and Referral Physician's Services</i> <i>Surgery Performed In the Physician's Office</i> <i>Allergy Treatment/Injections</i> <i>Allergy Serum (dispensed by the physician in the office)</i>	No charge after \$10 office visit Copay No charge after \$10 office visit Copay No charge after \$10 office visit Copay No charge after either the office visit Copay or the actual charge, whichever is less No charge	Deductible, then 20% to Out-of-Pocket Maximum Deductible, then 20% to Out-of-Pocket Maximum Deductible, then 20% to Out-of-Pocket Maximum Deductible, then 20% to Out-of-Pocket Maximum Deductible, then 20% to Out-of-Pocket Maximum
Routine Foot Care	Not Covered, except for services associated with care of diabetes and peripheral vascular disease, when medically necessary	Not Covered, except for services associated with care of diabetes and peripheral vascular disease, when medically necessary Deductible, then 20% to Out-of-Pocket Maximum
Hearing Test <i>(covered under PCP to age 19)</i>	No charge after \$10 office visit Copay	In-network coverage only
Laboratory and Radiology Services	No charge	Deductible, then 20% to Out-of-Pocket Maximum
Outpatient Pre-Admission Testing <i>Primary Care Physician's Office Visit</i> <i>Specialist Office Visit Office Visit</i> <i>Outpatient Facility</i> <i>Independent X-ray and/or Lab Facility</i>	No charge for x-ray and/or lab services and outpatient facility. \$10 office visit Copay if other office visit services also provided	Deductible, then 20% to Out-of-Pocket Maximum
Outpatient Facility Services <i>Operating Room, Recovery Room, Procedure Room and Treatment Room</i>	No charge	Deductible, then 20% to Out-of-Pocket Maximum
Outpatient Professional Services <i>Surgeon, Radiologist, Pathologist, Anesthesiologist</i>	No Charge	Deductible, then 20% to Out-of-Pocket Maximum
Inpatient Hospital - Facility Service <i>Semi-Private Room and Board</i>	No charge	Deductible, then 20% to Out-of-Pocket Maximum
Inpatient Hospital Physician's Visits/Consultations	No charge	Deductible, then 20% to Out-of-Pocket Maximum
Inpatient Hospital Professional Services <i>Surgeon, Radiologist, Pathologist, Anesthesiologist</i>	No charge	Deductible, then 20% to Out-of-Pocket Maximum
Inpatient Services at Other Health Care Facilities <i>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</i> <i>100 days per Contract Year, combined maximum in and out of network</i> <i>No prior hospitalization required</i>	No charge	Deductible, then 20% to Out-of-Pocket Maximum

BENEFIT HIGHLIGHTS	IN-NETWORK No Referrals Necessary	OUT-OF-NETWORK
<p>Emergency and Urgent Care Services</p> <p><i>Physician's Office</i></p> <p><i>Hospital Emergency Room</i></p> <p><i>Urgent Care Facility or Outpatient Facility</i></p> <p><i>Ambulance</i></p>	<p>No charge after \$10 office visit Copay</p> <p>No charge after \$50 per visit Copay* (Copay waived if admitted)</p> <p>No charge after \$25 per visit Copay</p> <p>No charge* * If not a true Emergency, services are not covered</p>	<p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>No charge after \$50 per visit Copay* (Copay waived if admitted)</p> <p>No charge after \$25 per visit Copay</p> <p>No charge* *If not a true Emergency, services are not covered</p>
<p>Outpatient Short-Term Rehabilitative Therapy</p> <p><i>60 visits per Contract Year, combined maximum in and out of network – Includes:</i></p> <p><i>Cardiac rehab</i></p> <p><i>Physical Therapy</i></p> <p><i>Speech Therapy</i></p> <p><i>Occupational Therapy</i></p> <p><i>Pulmonary Therapy</i></p>	<p>No charge after \$10 office visit Copay</p> <p>Note: Therapy as part of a CG approved Home Health Care plan, accumulates to the Outpatient Short-Term Rehabilitative maximum.</p>	<p>Deductible, then 20% to Out-of-Pocket Maximum</p>
<p>Chiropractic Therapy</p> <p><i>20 visits per Contract Year, combined maximum in and out of network</i></p>	<p>No charge after \$10 office visit Copay</p>	<p>Deductible, then 20% to Out-of-Pocket Maximum</p>
<p>Acupuncture*</p> <p><i>12 visits per Contract Year. Subject to CIGNA HealthCare Guidelines. See Section 4.A.</i></p>	<p>No charge after \$10 office visit Copay</p>	<p>Deductible, then 20% to Out-of-Pocket Maximum</p>
<p>Home Health Care</p> <p><i>(Includes outpatient private duty nursing when approved by CG as Medically Necessary. Note: The maximum number of hours per day is limited to 16. Multiple visits can occur in one day, with a visit defined as a period of two hours or less (maximum of eight visits per day).</i></p>	<p>No charge</p>	<p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>40 visits per Contract Year</p>
<p>Hospice</p> <p><i>Inpatient Services</i></p> <p><i>Outpatient Services</i></p>	<p>No charge</p> <p>No charge</p>	<p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>Deductible, then 20% to Out-of-Pocket Maximum</p>
<p>Maternity Care Services</p> <p><i>Initial Visit to Confirm Pregnancy</i></p> <p><i>All subsequent Prenatal Visits, Postnatal Visits and Delivery</i></p> <p><i>Delivery (Inpatient Hospital, Birthing Center)</i></p>	<p>No charge after \$10 office visit Copay</p> <p>No charge</p> <p>No charge</p>	<p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>Deductible, then 20% to Out-of-Pocket Maximum</p>

BENEFIT HIGHLIGHTS	IN-NETWORK No Referrals Necessary	OUT-OF-NETWORK
<p>Abortion Includes elective and non-elective procedures</p> <p><i>Office Visit</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Surgical Facility</i></p> <p><i>Physician's Services</i></p>	<p>No charge after \$10 office visit Copay</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>Deductible, then 20% to Out-of-Pocket Maximum</p>
<p>Family Planning Services</p> <p><i>Office Visit (tests, counseling)</i></p> <p><i>Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Physician's Services</i></p>	<p>No charge after \$10 office visit Copay</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>Deductible, then 20% to Out-of-Pocket Maximum</p>
<p>Infertility Treatment</p> <p><i>Coverage will be provided for the following services:</i></p> <p><i>Testing and treatment services performed in connection with an underlying medical condition;</i></p> <p><i>Testing performed specifically to determine the cause of infertility;</i></p> <p><i>Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition;</i></p> <p><i>Artificial Insemination.</i></p> <p><i>Office Visit (Test, Counseling)</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Services Not Covered include, but are not limited, to In-vitro, GIFT, ZIFT, and infertility drugs.</i></p>	<p>No charge after specialist \$10 office visit Copay</p> <p>No charge</p> <p>No charge</p>	<p>Deductible, then 20% to Out-of-Pocket Maximum</p>

BENEFIT HIGHLIGHTS	IN-NETWORK No Referrals Necessary	OUT-OF-NETWORK
<p>Organ Transplants Includes all medically appropriate, non-experimental transplants Office Visit</p> <p>Inpatient Facility Inpatient Physician's Services</p> <p>Travel Maximum</p>	<p>Benefits provided through the CIGNA LIFESOURCE Organ Transplant Network</p> <p>No charge after specialist \$10 office visit Copay</p> <p>No charge No charge</p> <p>\$10,000 per transplant/per lifetime maximum (only available when using CIGNA LIFESOURCE facility)</p>	<p>In-network coverage only</p> <p>Not Covered</p>
<p>Durable Medical Equipment \$5,000 per person per Contract Year, combined in and out of network maximum (unlimited for post-mastectomy breast reconstruction and breast prosthesis)</p>	<p>Member Coinsurance of 20%</p>	<p>Deductible, then 20% to Out-of-Pocket Maximum</p>
<p>External Prosthetic Appliances \$10,000 per person per Contract Year, combined in and out of network maximum (unlimited for breast reconstruction and breast prosthesis)</p>	<p>Member Coinsurance of 20%</p>	<p>Deductible, then 20% to Out-of-Pocket Maximum</p>
<p>Dental Care Charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth. Removal of boney impacted wisdom teeth. Physician's Office</p> <p>Inpatient Facility</p> <p>Outpatient Surgical Facility</p> <p>Physician's Services</p>	<p>(Prior Authorization Required for Dental Care)</p> <p>No charge after \$10 office visit Copay</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>(Prior Authorization Required for Dental Care)</p> <p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>Deductible, then 20% to Out-of-Pocket Maximum</p>
<p>Prescription Drugs CIGNA Pharmacy Retail Drug Program</p> <p>Includes oral contraceptives and contraceptive devices</p>	<p>\$5 per 30-day supply for generic drugs \$15 per 30-day supply for preferred brand name drugs \$35 per 30-day supply for non-preferred brand name drugs</p>	<p>In-network coverage only</p>
<p>CIGNA Tel-Drug Mail Order Drug Program Mandatory Mail Order Program</p> <p>Includes oral contraceptives and contraceptive devices</p>	<p>\$5 per 90-day supply for generic drugs \$15 per 90-day supply for preferred brand name drugs \$35 per 90-day supply for non-preferred brand name drugs</p>	<p>In-network coverage only</p>

BENEFIT HIGHLIGHTS	IN-NETWORK No Referrals Necessary	OUT-OF-NETWORK
<p><i>Mental Health/ Substance Abuse</i> <i>(Benefits listed below are combined Contract Year maximums for both Mental Health and Substance Abuse Benefits.)</i></p> <p><i>Inpatient Hospitalization</i></p> <p><i>Outpatient</i></p>	<p>\$0 Copay</p> <p>No charge after \$10 office visit Copay</p>	<p>Deductible, then 20% to Out-of-Pocket Maximum</p> <p>Deductible, then 20% to Out-of-Pocket Maximum</p>
<p><i>Pre-Existing Condition Limitation (PCL)</i></p>	<p>Not Applicable</p>	<p>Not Applicable</p>
<p><i>Pre-Admission Certification – Continued Stay Review required for all Inpatient Admissions.</i></p>	<p>Coordinated by Participating Provider and CG</p>	<p>Mandatory: Employee is responsible for contacting CG and receiving, in writing, Pre-Admission Certification. Penalties for non-compliance: \$500 applied to hospital inpatient charges for failure to contact CG to pre-certify admission.</p> <p>Benefits are denied for any admission reviewed by CG and not certified.</p> <p>Benefits are denied for additional days not certified by CG.</p>
<p><i>Prior Authorization required for selected outpatient procedures and diagnostic testing.</i></p>	<p>Coordinated by Participating Provider and CG</p>	<p>Mandatory: Employee is responsible for contacting CG and receiving, in writing, prior-authorization; otherwise benefits are denied.</p>
<p><i>Case Management</i></p>	<p>Coordinated by CG. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.</p>	

Benefit Exclusions

Your POS Open Access provides coverage for Medically Necessary services.

It does not provide coverage for the following (by way of example, but not limited to):

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury, which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Health Benefits Booklet.
6. Assistance in the activities of daily living including, but not limited to, eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the CG Physician Reviewer to be: not demonstrated through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its

use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" Section 4. J.

8. Cosmetic Services, including 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.
9. The following services are excluded from coverage regardless of clinical indications: acupressure, macromastia or gynecomastia surgery, rhinoplasty, blepharoplasty, redundant skin surgery, removal of skin tags, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy, and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
10. Treatment of TMJ disorder. But see Section 5. B. (3) of this Health Benefits Booklet.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth including, but not limited to, dental x-rays, examinations, repairs, extractions, orthodontics, dental implants, periodontics, casts, splints and services for dental malocclusion for any condition. Exceptions: Removal of boney impacted wisdom teeth is a Covered Service. Also, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% boney support and are functional in the arch. Dental implants are not covered for any condition.
12. 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.
13. Court ordered treatment or hospitalization, unless such treatment is being sought by a Physician and approved by CG.
14. Infertility drugs, in vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm. Cryopreservation of donor sperm and eggs are also excluded.
15. Reversal of male and female voluntary sterilization procedures.
16. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
17. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction including, but not limited to, anorgasmia, erectile dysfunction and premature ejaculation. However, penile implants and certain medications may be covered, subject to Medical Necessity and CG approval.
18. Medical and Hospital care and costs for the infant child of a Dependent.
19. Non-medical counseling or ancillary services including, but not limited to, Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities or developmental delays, autism or mental retardation.
20. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance including, but not limited to, routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
21. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in Section 4 of this Health Benefits Booklet.
22. Private hospital rooms and/or private duty nursing unless approved by the CG Physician Reviewer.
23. 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 illness or injury.
24. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, garter belts, corsets and dentures.
25. Hearing aids including, but not limited to, semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound. But see section 4. M. (coverage for children under age 19).
26. Aids or devices that assist with non-verbal communications including, but not limited to, communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
27. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).

28. Eye exercises and surgical treatment for the correction of refractive errors, including radial keratotomy, conductive keratoplasty and related procedures.
29. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
30. Orthotic devices, except as otherwise noted in Section 4. N.
31. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
32. Ultrasound or any other procedures requested solely for sex determination of the fetus.
33. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
34. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where, in the CG Physician Reviewer's opinion, the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
35. Blood administration for the purpose of general improvement in physical condition.
36. Physical examinations, the cost of biologicals that are immunizations or medications, and all other medical services required for the purpose of travel, employment or by other third parties, including protection against occupational hazards and risks.
37. Cosmetics, dietary supplements and health and beauty aids.
38. Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan. See Section 11, Coordination of Benefits.
39. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
40. Charges in excess of Reasonable and Customary.
41. Massage Therapy.

This Schedule highlights benefits available under POS Open Access plan. A complete description regarding the terms of coverage, exclusions and limitations are provided in this Health Benefits Booklet.

Benefits are administered by Connecticut General Life Insurance Company.

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Open Access + Schedule of Benefits

In the Open Access + you do not need to select a Primary Care Physician.* No Referrals are necessary to receive Covered Services from other providers in the CIGNA HealthCare network. The plan encourages use of Preventive Care, with no Deductibles, Copays or Coinsurance. Other Covered Services are subject to a Deductible and Coinsurance until you reach an out-of-pocket maximum for the Contract Year. Members enrolled in the Open Access + receive benefits only if they use CIGNA HealthCare Providers.

The following chart is a Schedule of Benefits for the Open Access + plan.

**While not required to select a Primary Care Physician (PCP), Members are encouraged to establish and maintain a relationship with a PCP to meet Preventive and basic health care needs. Also, a Primary Care Physician may be helpful in coordinating your care and initially arranging referrals to specialists.*

Schedule of Benefits
SCHOOLCARE
Open Access +

BENEFIT HIGHLIGHTS		IN-NETWORK (No Referrals Necessary)
<i>Lifetime Maximum</i>	<i>Unlimited</i>	
Contract Year Deductible		
<i>Individual</i>	\$250	
<i>Family Maximum</i>	\$500	
<i>Aggregate</i>	Yes	
Coinsurance	20%	
Out-of-Pocket Maximum		
<i>Includes Coinsurance</i>	Yes	
<i>Includes Deductible</i>	Yes	
<i>Includes Copays for Pharmacy, Emergency and Urgent Care Services</i>	No	
<i>Individual</i>	\$1,000 per Contract Year	
<i>Family Maximum</i>	\$2,000 per Contract Year	
<i>Aggregate Does Not Apply To</i>	Non-compliance penalties	
		YOU PAY
Preventive Care		
<i>Routine Preventive Care - Adult, Well-Baby, Well-Child.</i>	\$0	
<i>Annual OB/GYN Exam</i>	\$0	
<i>Immunizations</i>	\$0	
<i>Routine Laboratory and Testing</i>	\$0	
<i>Routine Mammograms, PSA, PAP Smear</i>	\$0	
<i>Routine Laboratory and Testing</i>	\$0	
<i>Routine Vision Care</i>		
<i>Eye Exam every 12 months</i>	\$0	
<i>Eye Glasses/Contact Lenses not covered</i>		
<i>Hearing Test (covered to age 19 as part of routine Preventive Care)</i>	\$0	
Routine Foot Care	Not covered, except for services associated with care of diabetes and peripheral vascular disease, when Medically Necessary. Coverage is subject to Deductible, then 20% to Out-of-Pocket Maximum.	
Physician's Services		
<i>Primary Care Physician's Office Visit</i>	Deductible, then 20% to the Out-of-Pocket Maximum	
<i>Specialty Care Physician's Office Visit</i>		
<i>Office Visits</i>	Deductible, then 20% to the Out-of-Pocket Maximum	
<i>Consultant and Referral Physician's Services</i>	Deductible, then 20% to the Out-of-Pocket Maximum	
<i>Surgery Performed In the Physician's Office</i>	Deductible, then 20% to the Out-of-Pocket Maximum	
<i>Allergy Treatment/Injections</i>	Deductible, then 20% to the Out-of-Pocket Maximum	
<i>Allergy Serum (dispensed by the physician in the office)</i>	Deductible, then 20% to the Out-of-Pocket Maximum	

BENEFIT HIGHLIGHTS	IN-NETWORK (No Referrals Necessary)
Laboratory and Radiology Services	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Pre-Admission Testing <i>Primary Care Physician's Office Visit</i> <i>Specialist Physician's Office Visit</i> <i>Outpatient Facility</i> <i>Independent X-ray and/or Lab Facility</i>	Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Facility Services <i>Operating Room, Recovery Room, Procedure Room and Treatment Room</i>	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Professional Services <i>Surgeon, Radiologist, Pathologist, Anesthesiologist</i>	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Hospital - Facility Services <i>Semi-Private Room and Board</i>	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Hospital Physician's Visits/Consultations	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Hospital Professional Services <i>Surgeon, Radiologist, Pathologist, Anesthesiologist</i>	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Services at Other Health Care Facilities <i>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</i> <i>100 days combined maximum per Contract Year</i> <i>No prior hospitalization required.</i>	Deductible, then 20% to the Out-of-Pocket Maximum
Emergency and Urgent Care Services <i>Physician's Office</i> <i>Hospital Emergency Room</i> <i>Urgent Care Facility or Outpatient Facility</i> <i>Ambulance</i>	Deductible, then 20% to the Out-of-Pocket Maximum No charge after \$50 per visit Copay* (Copay waived if admitted) No charge after \$25 per visit Copay Deductible, then 20% to the Out-of-Pocket Maximum* * If not a true Emergency, services are not covered.
Outpatient Short-Term Rehabilitative Therapy <i>60 visits combined maximum per Contract Year</i> <i>Includes:</i> <i>Cardiac Rehab</i> <i>Physical Therapy</i> <i>Speech Therapy</i> <i>Occupational Therapy</i> <i>Pulmonary Therapy</i>	Deductible, then 20% to the Out-of-Pocket Maximum Note: Therapy as part of a CG approved Home Health Care plan, accumulates to the Outpatient Short-Term Rehabilitative maximum.
Chiropractic Therapy <i>20 visits per Contract Year</i>	Deductible then 20% to Out-of-Pocket Maximum
Acupuncture* <i>12 visits per Contract Year</i> <i>*Subject to CIGNA HealthCare Guidelines. See Section 4.A.</i>	Deductible, then 20% to Out-of-Pocket Maximum

BENEFIT HIGHLIGHTS	IN-NETWORK (No Referrals Necessary)
<p>Home Health Care <i>(includes outpatient private duty nursing when approved by CG as Medically Necessary)</i></p> <p><i>Note: The maximum number of hours per day is limited to 16. Multiple visits can occur in one day, with a visit defined as a period of two hours or less (maximum of eight visits per day).</i></p>	Deductible, then 20% to Out-of-Pocket Maximum
<p>Hospice <i>Inpatient Services</i> <i>Outpatient Services</i></p>	Deductible, then 20% to Out-of-Pocket Maximum Deductible, then 20% to Out-of-Pocket Maximum
<p>Maternity Care Services <i>Initial Visit to Confirm Pregnancy</i> <i>All subsequent Prenatal Visits, Postnatal Visits and Delivery</i> <i>Delivery (Inpatient Hospital, Birthing Center)</i></p>	Deductible, then 20% to Out-of-Pocket Maximum Deductible, then 20% to Out-of-Pocket Maximum Deductible, then 20% to Out-of-Pocket Maximum
<p>Abortion <i>Includes elective and non-elective procedures</i> <i>Office Visit</i> <i>Inpatient Facility</i> <i>Outpatient Surgical Facility</i> <i>Physician's Services</i></p>	Deductible, then 20% to Out-of-Pocket Maximum Deductible, then 20% to Out-of-Pocket Maximum Deductible, then 20% to Out-of-Pocket Maximum Deductible, then 20% to Out-of-Pocket Maximum
<p>Family Planning Services <i>Office Visit (tests, counseling)</i> <i>Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)</i> <i>Inpatient Facility</i> <i>Outpatient Facility</i> <i>Physician's Services</i></p>	Deductible, then 20% to Out-of-Pocket Maximum Deductible, then 20% to Out-of-Pocket Maximum Deductible, then 20% to Out-of-Pocket Maximum Deductible, then 20% to Out-of-Pocket Maximum
<p>Infertility Treatment <i>Coverage will be provided for the following services:</i> <i>Testing and treatment services performed in connection with an underlying medical condition;</i> <i>Testing performed specifically to determine the cause of infertility;</i> <i>Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition);</i> <i>Artificial Insemination.</i> <i>Office Visit (Test, Counseling)</i> <i>Inpatient Facility</i> <i>Outpatient Facility</i> <i>Services not covered include, but are not limited to, In-vitro, GIFT, ZIFT, and Infertility Drugs</i></p>	Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum

BENEFIT HIGHLIGHTS	IN-NETWORK (No Referrals Necessary)
<p>Organ Transplants Includes all medically appropriate, non-experimental transplants Office Visit Inpatient Facility Inpatient Physician's Services Travel Maximum</p>	<p>Benefits provided through the CIGNA LIFESOURCE Organ Transplant Network</p> <p>Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum \$10,000 per transplant/per lifetime maximum (only available when using a CIGNA LIFESOURCE facility)</p>
<p>Durable Medical Equipment (DME) \$5,000 per person, per Contract Year (unlimited for post-mastectomy breast reconstruction and breast prosthesis)</p>	<p>Deductible, then 20% to the Out-of-Pocket Maximum</p>
<p>External Prosthetic Appliances \$10,000 per person, per Contract Year (unlimited for post-mastectomy breast reconstruction and breast prosthesis)</p>	<p>Deductible, then 20% to the Out-of-Pocket Maximum</p>
<p>Dental Care Charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth. Removal of boney impacted wisdom teeth. Physician's Office Inpatient Facility Outpatient surgical Facility Physician's Services</p>	<p>(Prior Authorization Required for Dental Care)</p> <p>Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum</p>
<p>Prescription Drugs CIGNA Pharmacy Retail Drug Program Includes oral contraceptives and contraceptive devices</p>	<p>\$5 per 30-day supply for generic drugs \$15 per 30-day supply for preferred brand name drugs \$35 per 30-day supply for non-preferred brand name drugs</p>
<p>CIGNA Tel-Drug Mail Order Drug Program Mandatory Mail Order Program Includes oral contraceptives and contraceptive devices</p>	<p>\$0 per 90-day supply for generic drugs \$15 per 90-day supply for preferred brand name drugs \$35 per 90-day supply for non-preferred brand name drugs</p>
<p>Mental Health/ Substance Abuse Inpatient Hospitalization Outpatient</p>	<p>\$0 \$0</p>
<p>Pre-Existing Condition Limitation</p>	<p>Not Applicable</p>
<p>Pre-Admission Certification-Continued Stay Review required for all Inpatient Admissions</p>	<p>Coordinated by Participating Provider and CG</p>
<p>Prior Authorization required for selected outpatient procedures and diagnostic testing.</p>	<p>Coordinated by Participating Provider and CG</p>
<p>Case Management</p>	<p>Coordinated by CG. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.</p>

Benefit Exclusions

Your Open Access + provides coverage for Medically Necessary services.

It does not provide coverage for the following (*by way of example, but not limited to*):

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury, which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Health Benefits Booklet.
6. Assistance in the activities of daily living including, but not limited to, eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the CG Physician Reviewer to be: not demonstrated through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" Section 4. J.
8. Cosmetic Services including 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.
9. The following services are excluded from coverage regardless of clinical indications: acupressure; macromastia or gynecomastia surgery, rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
10. Treatment of TMJ disorder. But see Section 5. B. (3) of this Health Benefits Booklet.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth including, but not limited to, dental x-rays, examinations, repairs, extractions, orthodontics, dental implants, periodontics, casts, splints and services for dental malocclusion for any condition. Exceptions: Removal of boney impacted wisdom teeth is a Covered Service. Also, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% boney support and are functional in the arch. Dental implants are not covered for any condition.
12. 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.
13. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician and approved by CG.
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15. Reversal of male and female voluntary sterilization procedures.
16. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
17. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction, including, but not limited to, anorgasmia, erectile dysfunction and premature ejaculation. However, penile implants and certain medications may be covered, subject to Medical Necessity and CG approval.
18. Medical and Hospital care and costs for the infant child of a Dependent.
19. Non-medical counseling or ancillary services including, but not limited to, Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities or developmental delays, autism or mental retardation.

20. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance including, but not limited, to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
21. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in Section 4 of this Health Benefits Booklet.
22. Private hospital rooms and/or private duty nursing unless approved by the CG Physician Reviewer.
23. 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 illness or injury.
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25. Hearing aids including, but not limited to, semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound. But see section 4. M. (coverage for children under age 19).
26. Aids or devices that assist with non-verbal communications including, but not limited to, communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
27. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
28. Eye exercises and surgical treatment for the correction of refractive errors including radial keratotomy, conductive keratoplasty and related procedures.
29. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
30. Orthotic devices, except as otherwise noted in Section 4. N.
31. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
32. Ultrasound or any other procedures requested solely for sex determination of the fetus.
33. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
34. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where, in the CG Physician Reviewer's opinion, the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
35. Blood administration for the purpose of general improvement in physical condition.
36. Physical examinations, the cost of biologicals that are immunizations or medications, and all other medical services required for the purpose of travel, employment or by other third parties including protection against occupational hazards and risks.
37. Cosmetics, dietary supplements and health and beauty aids.
38. Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan. See Section 11, Coordination of Benefits.
39. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
40. Charges in excess of Reasonable and Customary.
41. Massage Therapy.

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4. BENEFITS AND SERVICES (additional information)

Only Medically Necessary services as determined by CG or its designated representative are covered, and will be rendered at the most appropriate, cost-effective supply or level that can safely be provided to the Member. All benefits and services are subject to the Copays, Deductibles, Coinsurance, exclusions, limitations, and conditions noted in the Schedules of Benefits and this Health Benefits Booklet.

A. Outpatient Services.

- (1) Adult and pediatric health examinations.
- (2) Diagnosis and treatment services, including lab and X-ray.
- (3) Charges for genetic testing that use proven testing methods for the identification of genetically linked inheritable disease. Genetic testing is covered only if a person has symptoms or signs of a genetically linked inheritable disease; it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based scientific literature for the development of a genetically linked inheritable disease when the results will impact clinical outcome; or the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based scientific literature to directly impact treatment options. Genetic counseling is covered if the Member is undergoing approved genetic testing, or has an inherited disease, or is a potential candidate for genetic testing. Genetic counseling is limited to three visits per Contract Year for both pre- and post-genetic testing.
- (4) Family planning services including medical history, physical examination, related laboratory tests, medical supervision and other medical services in accordance with generally accepted medical practice. Also included under family planning services: information and counseling on contraception, implanted/injected contraceptives, and after appropriate counseling, medical services connected with surgical therapies (vasectomy or tubal ligation).
- (5) Short-term nutritional evaluation and counseling. Information and pre-approved health education rendered by a licensed or certified provider when diet is a part of the medical management of a documented organic disease, including clinically severe obesity, asthma, high cholesterol and diabetes.
- (6) Early Intervention Services. Coverage for Medically Necessary services provided by licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers rendered to a Dependent child with an identified developmental disability and/or delay. Benefits are limited to Dependent children from birth until the Dependent child's third birthday, and subject to a maximum benefit of \$3,200 per Dependent child, per Contract Year. The benefits are subject to all applicable Deductibles, Coinsurance and Copay provisions as outlined in the Schedules of Benefits (Section 3.).
- (7) Diabetic services including self-management training, which provide instruction about the disease and its control, educational services and medical nutritional therapy. Diabetic supplies, including blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading, urine testing strips, insulin, injection aids, cartridges for the visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices and oral agents for controlling blood sugar.
- (8) Immunizations and injections for the prevention and detection of diseases. But see Section 5. A. (24).
- (9) Maternity care, including medical, surgical and Hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy.
- (10) Outpatient surgical services, including anesthesia and recovery room services in a Hospital or Outpatient Surgical Facility.
- (11) Short-term Outpatient Rehabilitative Services that are part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulation, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most Medically Appropriate setting. Speech therapy is not covered when used to improve speech skills

that have not fully developed, except when speech is not fully developed in children (under age 19) due to an underlying disease or malformation that prevented speech development. Speech therapy is not covered when intended to maintain speech communication and is not restorative in nature. Occupational therapy is limited to services provided only for purposes of enabling a patient to perform the activities of daily living after an illness or injury.

Short-term Rehabilitative Services which are not covered include, but are not limited to, the following:

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

All Services listed under paragraph (11) are not covered when they are considered custodial or educational in nature. Also, see Section 4. A. (6).

- (12) Chiropractic care. Diagnostic and treatment services utilized in an office setting by Chiropractic physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

The following are specifically excluded from chiropractic care services:

- Services of a Chiropractor that are not within the scope of practice, as defined by law;
- Charges for care not provided in an office setting;
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care to prevent reoccurrence or to maintain the patient's current status; and
- Vitamin therapy.

- (13) Acupuncture when provided by a licensed or certified acupuncturist for the following indications only:

- Nausea and vomiting associated with pregnancy;
- Nausea and vomiting associated with chemotherapy;
- Post-operative nausea and vomiting;
- Post-operative dental pain, if the treatment of the dental condition was a Covered Service under this Health Benefits Booklet or
- As an adjunct to standard therapy when conservative methods have failed for either of the following conditions: chronic headaches or chronic pain (limited to osteoarthritis of the knee, chronic back pain and neck pain).

Note: CIGNA does not have a network of acupuncturists. The Member may use any licensed or certified practitioner. No referral is necessary. See the Schedules of Benefits for limitations on the number of visits and amount of reimbursement. The Member may be required by the acupuncturist to pay at the time of service and then submit the claim to CIGNA at the address on the reverse of the Member's ID card.

B. Inpatient Services. The following inpatient services are provided for an unlimited number of days upon admission to a Hospital only when admission is authorized by the Member's Physician and CG. Before or upon admission to a Hospital, the patient's care may be subject to case management by CG to plan a patient's ongoing medical care, discharge or after care. Follow-up services are covered only when authorized and/or provided by the Member's Physician and/or CG. These inpatient services include:

- (1) Room and board in a semi-private room (or private room when Medically Necessary and CG approved), including confinement in an intensive care unit.
- (2) Inpatient skilled nursing care is available when admission to a facility is authorized by the Member's PCP and/or CG. CG does not cover custodial confinements.

- (3) Blood transfusion services, blood and blood products;
- (4) Drugs, medications, biologicals, fluids and chemotherapy;
- (5) Hospital ancillary services including but not limited to, use of operating room, and related facilities; anesthesia and associated services, radiology and other diagnostic and therapeutic services; general nursing services; inhalation therapy; radiation therapy; special diets; dressings and casts; and other services which are customarily provided in acute care Hospitals.
- (6) Newborn care, including routine well baby charges.
- (7) Physician services.

C. Ambulance Services. Emergency transportation to the nearest appropriate provider or facility when required to treat a sudden, unexpected onset of a bodily injury or serious illness which could reasonably be expected by a prudent layperson to result in serious medical complications or permanent impairment to bodily functions in the absence of immediate medical attention; or when the member is transported from one inpatient facility to another as ordered by the attending physician and approved by CG. Air/Water ambulance services may be covered if determined by CG to be Medically Necessary.

D. Breast Reconstruction and Breast Prostheses. Refer to the Schedules of Benefits in Section 3 for coverage under Durable Medical Equipment (DME) and External Prosthetic Appliances (EPA). For post-mastectomy, the following are covered benefits:

- (1) Surgical services for reconstruction of the breast on which surgery was performed;
- (2) Surgical services for reconstruction of the non-diseased breast to produce a symmetrical appearance;
- (3) Post-operative breast prostheses; and
- (4) Mastectomy bras, garments and external prosthetics limited to the lowest cost alternative available that meets external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications including lymphedema therapy, are covered.

E. Dialysis. Dialysis (Hemodialysis or Peritoneal) treatment for a Member with End Stage Renal Disease (ESRD) or acute renal (kidney) conditions, but only if the Participating Provider and CG determine that this represents the preferred method of treatment. Special Coordination of Benefit rules may apply if the member is eligible for Medicare due to ESRD.

F. Emergency Services. In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest Hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral from your PCP for Emergency Services, but you do need to call your PCP or CG within forty-eight (48) hours for further assistance and advice on follow-up care. If you require specialty care or a Hospital admission, your PCP and CG will coordinate and handle the necessary authorizations for care or hospitalization. Participating Providers are on call twenty-four (24) hours a day, seven (7) days a week to assist you when you need Emergency Services.

If you receive Emergency Services outside your service area, you must notify CG as soon as reasonably possible. We may arrange to have you transferred to a Participating Provider for continuing or follow-up care if it is determined to be medically safe to do so. Continuing or follow-up treatment out of the service area is not covered unless Prior Approval is obtained from CG. Please refer to Section 2 of this Health Benefits Booklet for the definition of Emergency Services.

G. Home Health Services. Home Health Services are provided for a Member who:

- (1) Requires skilled care;
- (2) Is unable to obtain the required care as an ambulatory outpatient; and
- (3) Does not require confinement in a Hospital or Other Participating Health Care Facility.

Home Health Services are provided only if CG has determined that the home is a Medically Appropriate and cost-effective setting and has authorized such services for the Member in advance. If the member is a minor or an adult who is dependent upon others for non-skilled

care and/or Custodial Care (e.g. bathing, eating, toileting, etc.), home health services will only be provided during times when there is a family member or caregiver present in the home to meet any non-skilled and/or Custodial services.

Home Health Services are those skilled health care services, which can be provided during visits by participating health care professionals, and does not include services by a person who is a member of the patient's family, or who normally resides in the home, even if the person is a participating health care professional. Skilled nursing services or private duty nursing services provided in the home are subject to CG approval. Home Health Services are subject to a maximum of 16 hours in total per day, and a visit is defined as a period of two (2) hours or less. Necessary consumable medical supplies and home infusion therapy administered or used by health care professionals in providing Home Health Services are covered.

H. Organ Transplants and Related Services. With Prior Authorization from CG's Physician Reviewer, **SCHOOLCARE** provides the following benefits for human organ and tissue transplant services at participating, designated facilities throughout the United States, subject to the conditions and limitations below.

- (1) **Definition of Transplant Services.** Transplant services include the recipient's medical, surgical and hospital services, inpatient immunosuppressive medications, and organ procurement required to perform any of the following human to human organ or tissue transplants: allogenic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or small bowel/liver.
- (2) **Prior Authorization.** Coverage for transplant services must be authorized by CG's Physician Reviewer based on Medical Necessity. All Organ Transplant Services, other than cornea, kidney and autologous bone marrow/stem cell transplants, must be received at a qualified or provisional CIGNA LIFESOURCE Organ Transplant Network facility.
- (3) **Organ Procurement Costs.** Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary and authorized by CG. Costs related to the search and identification of a bone marrow or stem cell donor for an allogeneic transplant are covered.
- (4) **Human Leukocyte Antigen Testing.** Coverage includes human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability, and the cost of testing for A, B or DR antigens, or any combinations thereof.

Organ Transplant Travel Services. Travel expenses incurred by a Member in connection with a pre-approved organ/tissue transplant are covered subject to the conditions and limitations below. All expenses must be authorized in advance by CG or in accordance with the Organ Transplant Travel Services guidelines. Organ Transplant Travel Services are not available for cornea, kidney and autologous bone marrow/stem cell transplants. Benefits for transportation, lodging and food are available to Members only if they are the recipient of a pre-approved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following:

- (1) Evaluation;
- (2) Candidacy;
- (3) Transplant event; or
- (4) Post-transplant care.

These services are subject to a \$10,000 lifetime maximum.

Travel expenses for the Member receiving the transplant will include charges for:

- (1) Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
- (2) Lodging while at or traveling to and from the transplant site; and
- (3) Food while at or traveling to and from the transplant site.

In addition to the Member being covered for the charges associated with the items (1), (2) and (3) above, such charges will also be considered covered travel expenses for one companion to accompany recipient. In the case of a minor recipient, these items will be considered a covered expense for both parents. The term companion includes a spouse, family member, Member's legal guardian, or any person not related to the Member, but actively involved the Member's care.

By way of example, but not of limitation, the following are specifically excluded travel expenses:

- (1) Transplant travel benefit costs incurred due to travel within 60 miles of your home;
- (2) Laundry bills;
- (3) Telephone bills;
- (4) Alcohol or tobacco products; or
- (5) Transportation charges which exceed coach class rates.

Organ Transplant Travel Services are only available when the Member is the recipient of the transplant. No benefits are available when the Member is a donor.

- I. Mental Health and Substance Abuse Services.** A Member may schedule care for Mental Health or Substance Abuse treatment directly or through the Mental Health Referral Organization. The Member will receive treatment from Physicians, Hospitals and other providers that participate with the Mental Health Referral Organization. Additional Information may be obtained from the CIGNA HealthCare Provider Directory or by calling the MH/SA telephone number on the reverse of your Identification Card. CG provides services necessary for the diagnosis, crisis intervention, and treatment of acute psychiatric conditions, including treatment for mental illness or disorders and psychiatric testing. CG provides substance abuse services including diagnosis, medical treatment, detoxification and rehabilitation. All services must, in the judgment of CG or the Mental Health Referral Organization, lead to significant improvement through short-term therapy and be found Medically Necessary by CG or the Mental Health Referral Organization.

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

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

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

J. Clinical Trials for Treatment Studies on Cancer and Life-threatening Conditions.

Coverage shall be provided for all Medically Necessary routine patient care costs incurred as a result of treatment being provided in accordance with a clinical trial to the extent such costs would be covered for non-investigational treatments if the treatment provided or the studies conducted in a phase I, phase II, phase III, or phase IV clinical trial for cancer or the treatment is being provided for any other life threatening condition. Coverage for phase I or phase II clinical trials shall be decided by CG on a case by case basis. Routine patient care costs means the cost for any Medically Necessary health care services that are incurred as a result of the treatment being provided to a Member. Routine patient care costs are those for which **SCHOOLCARE** regularly reimburses its Members, health care providers, or health care institutions, subject to the terms and condition of this Health Benefits Booklet and the provider's service agreement with CG.

The following criteria are required:

- (1) The treatment provided to the Member in a clinical trial is approved by
 - One of the National Institutes of Health (NIH);
 - An NIH cooperative group or a NIH center;
 - The FDA in the form of an investigational new drug application or exemption;
 - The federal department of Veterans Affairs or Defense; or
 - An institutional review board of an institution in this state that has a multiple assurance contract approved by the Office of Protection from Research Risks of the NIH.
- (2) Standard treatment has been or would be ineffective, does not exist, or there is no superior non-investigational treatment alternative;
- (3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and the volume of patients treated to maintain expertise; and,
- (4) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.

Coverage shall be provided for routine patient care for drugs and devices provided to the Member during the clinical trial, which are not the subject of the clinical trial; provided that those drugs or devices have been approved for sale by the FDA, whether or not the FDA has approved the drug or device for use in treating the Member's particular condition. This coverage shall include reasonable and Medically Necessary services to administer the drug or use the device under evaluation in the clinical trial.

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

- (1) The investigational service or supply itself;
- (2) Services or supplies not covered under the provisions of this Health Benefits Booklet
- (3) Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- (4) Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

K. Prescription Drug Benefit. See the Schedules of Benefits (Section 3) for Copays and other information.

The **SCHOOLCARE** benefit program provides coverage for Medically Necessary Prescription Drugs and related supplies ordered by a Physician and purchased from a CG Participating Pharmacy. Benefits are also provided for Prescription Drugs ordered by a licensed dentist for the prevention of infection or pain in conjunction with an invasive dental procedure.

Definitions:

- 1. Preferred Drug Formulary.** A list of prescription medications approved by the CG

Pharmacy & Therapeutics (P&T) Committee for inclusion in the pharmacy benefit. The Preferred Drug Formulary is subject to change upon review by the P&T Committee.

2. Preferred Brand Name Drug. A branded Prescription Drug that has been designated by the CG P&T Committee as a Preferred Brand on the Preferred Drug Formulary. Preferred Brand designation is based on safety, effectiveness and cost.

3. Generic Prescription Drug. A medication that meets all United States Food and Drug Administration (FDA) standards and has the same active ingredients and the same potency as the originally invented product. The generic is generally less expensive than the alternative Non-Preferred Brand Name drug.

4. Non-Preferred Brand Name Drugs. A branded Prescription Drug that has been designated by the CG P&T Committee as a Non-Preferred Brand on the Drug Formulary. Non-Preferred Brand drugs include drugs that (1) have a U.S. Food and Drug Administration (FDA) A-rated and/or P&T Committee approved generic equivalent; (2) were reviewed by the P&T Committee and found not to have a significant therapeutic advantage over preferred brands; and (3) are usually not recommended as first-line therapy and have alternative treatment modalities. Medications newly approved by the FDA will be classified as Non-Preferred until they are reviewed by the CG Pharmacy & Therapeutics P&T Committee. All drugs newly approved by the FDA are designated as Non-Formulary Prescription Drugs until the P&T Committee evaluates the prescription drug clinically and considers whether it may be placed on the formulary. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

5. Mail Order Prescription Drug Program. A Prescription Drug benefit feature that allows certain drugs designated by the CG P&T Committee to be filled up to a 90-day supply through a Participating Mail Order Pharmacy for the treatment of an ongoing medical condition. Drugs included in the Mail Order Prescription Drug Program are subject to change upon review by the P&T Committee.

6. Maintenance Prescriptions. Maintenance Prescription Drugs are those drugs which have been designated by the CG P&T Committee to be filled up to a 90-day supply through a Participating Mail Order Pharmacy for the treatment of an ongoing medical condition (such as hypertension or diabetes). Many drugs are included within this designation, but not all medications prescribed for ongoing conditions are included.

7. Retail Prescriptions filled at Participating Pharmacies are limited to a 30-day supply.

Covered Prescription Expenses

- (1) Medically Necessary Prescription Drugs for use outside the hospital;
- (2) FDA-approved Legend Drugs;
- (3) Insulin (on prescription) for the treatment of diabetes;
- (4) Compounded Medications when one of the ingredients is an FDA-approved Legend Drug;
- (5) Glucagon;
- (6) Birth control pills;
- (7) Prenatal vitamins; and
- (8) Ana-kits/Epipens/Ana-Guard;
- (9) Diabetic supplies, such as test strips, lancets and syringes.

Prior Authorization. Coverage for certain Prescription Drugs and related supplies require the prescribing Physician to obtain Prior Authorization from CG. Prescription Drugs that require Prior Authorization are identified on the Drug Formulary, and the forms required to obtain Prior Authorization are available on the CIGNA HealthCare Website at www.cigna.com. If the prescribing Physician wishes to request coverage for a Prescription Drug or related supply for which Prior Authorization is required, he or she may call CG or complete the appropriate Prior Authorization form and fax it to CG. Your physician should

make this request before writing the Prescription. If the request is approved, your Physician will receive confirmation from CG. The authorization will be processed in CG's claim system to allow the Member to have coverage for that Prescription Drug or related supply. The length of the authorization will depend on the diagnosis and the Prescription Drug or related supply. When your Physician advises you that coverage has been approved, you should contact the Participating Pharmacy to fill the Prescription. If the request is denied, notification will be sent to both the Member and the prescribing Physician that coverage for the Prescription Drug or related supply is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the Appeal Procedures in Section 13 of this Health Benefits Booklet. If you have questions about a Prior Authorization request, you should call Member Services at the toll-free number on your Identification Card.

Exclusions and Limitations:

- (1) Anti-obesity products and anorexiant, diet pills or appetite suppressants (anorectics).
- (2) Any drug that comes on the market after the effective date of this Health Benefits Booklet, unless CG specifically agrees to include the drug as a covered item.
- (3) Devices, other than diaphragms, even though such devices may require a prescription order, including but not limited to, therapeutic and other prosthetic devices, appliances and supports.
- (4) Drugs labeled "Caution—Limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual.
- (5) Drugs even if approved for treatment related to a non-covered procedure, including, but not limited to, Experimental or Cosmetic Services (e.g. Topical Minoxidal), drugs to reduce wrinkles, fade cream or to enhance hair growth. However, coverage includes Prescription Drugs dispensed to a Member by a licensed dentist for the prevention of infection or pain in conjunction with an invasive dental procedure.
- (6) Medical supplies (such as bandages) and other items required for certain medical procedures, medical tests, and maintenance care. However, ostomy supplies and urinary catheters are covered as a medical benefit under this plan.
- (7) Medications, except for insulin, which do not require a prescription, even if recommended by a Provider.
- (8) Any drugs available over the counter that do not require a prescription by federal law, and any drug that is a pharmaceutical alternative to an over the counter drug, other than insulin.
- (9) Any drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee (such as antihistamines).
- (10) Prophylactics, spermicidal jelly, contraceptive cream and foam; Norplant and other implantable contraceptive products.
- (11) Smoking cessation products or devices.
- (12) Prescription vitamins, other than prenatal vitamins.
- (13) Vaccines/immunizing agents (covered under the medical benefit).
- (14) Biological sera (covered under the medical benefit).
- (15) Allergy sera (covered under the medical benefit).
- (16) Injectable prescriptions that are not packaged and labeled by the manufacturer for self-administration, but typically require a healthcare professional to administer (covered under medical benefit). Upon Prior Authorization by CG, self-injectable drugs may be covered as a pharmacy benefit, subject to the required Copays.
- (17) Replacement of lost, stolen, or destroyed Prescriptions or related supplies are not covered.
- (18) Food and Drug Administration (FDA) approved Prescription Drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies

- published in a peer-reviewed national professional medical journal.
- (19) Nonprescription supplies, devices, and appliances, other than supplies Medically Necessary for the administration of Prescription Drugs covered by this plan.
 - (20) Any infertility drugs.
 - (21) Medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, anorgasmia, decreased libido and premature ejaculation. However, penile implants and certain medications may be covered, subject to Medical Necessity and CG approval.
 - (22) Dietary supplements and fluoride products.
 - (23) Drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products.
 - (24) Drugs used to enhance athletic performance.
 - (25) Drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals (covered under medical benefit).
 - (26) Prescriptions more than one year from the original date of issue.
 - (27) Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
 - (28) Other Exclusions and Limitations as noted in the Schedule of Benefits (Section 3) and in Section 5 of this Health Benefits Booklet.

Dispensing Limitations

Prescription refills in excess of the number specified by a Participating Provider or any refill dispensed more than one year after the date of the Physician's original order are excluded. Authorized refills will be allowed after 75% of a prescription's day-supply period has elapsed. Unless otherwise limited by the drug manufacturer's packaging or the P&T Committee, prescriptions will be covered up to a 30-day supply per prescription, or up to a 90-day supply for Maintenance Prescriptions under the Mail Order Prescription Drug Program.

Emergency Services

When a Member is issued a Prescription as part of rendering Emergency Services and that Prescription cannot reasonably be filled by a CG Participating Pharmacy, the Prescription will be covered at the same benefit level as if filled by a Participating Pharmacy.

Your Payments

Prescription Drugs and related supplies purchased at a Participating Pharmacy are subject to any applicable Copays or Coinsurance and/or Deductibles as shown in the Schedules of Benefits. In no event will any Copay exceed the cost of the Prescription Drug or related supply. When a treatment regimen contains more than one type of Prescription Drug, which is packaged together for the Member's convenience, a Copay will apply to each Prescription Drug.

Reimbursement/Filing a Claim

When a Member purchases Prescription Drugs or related supplies through a Participating Pharmacy, you pay only the appropriate Copay or Coinsurance noted in the Schedules of Benefits at the time of purchase. To purchase Prescription Drugs or related supplies from a Mail-Order Participating Pharmacy, see your mail-order drug introductory kit for details, or contact Member Services for assistance. In Emergency situations when it is not possible to fill the Prescription at a Participating Pharmacy, the Member will need to file a claim for reimbursement, minus any applicable Deductibles, Copays or Coinsurance. Claim forms are online at www.cigna.com or call Member Services for assistance.

L. Nutritional Formulas. Enteral formulas are covered when prescribed by a physician for the treatment of diseases including, but not limited to, Crohn's disease, gastroesophageal reflux with failure to thrive, disorders of gastrointestinal motility, such as chronic intestinal pseudo-obstruction, multiple and severe food allergies, which left untreated would cause malnourishment, chronic physical disability, mental retardation or death. Additionally, low protein modified food products will be covered when prescribed by a Physician for the treatment of inherited diseases of amino-acid or organic acid metabolism. Coverage under this Section shall be provided when the prescribing Physician has issued a written order stating that the enteral formula or modified food product is medically necessary and is the least restrictive and most cost effective means for meeting the needs of the patient.

M. Durable Medical Equipment. See the Schedules of Benefits for other information regarding the Contract Year benefit allowance and Coinsurance requirements.

Purchase or rental of durable medical equipment that is ordered or prescribed by a Physician and provided by a vendor approved by the CG for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a member's misuse are the member's responsibility. Durable medical equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of illness or injury; are appropriate for use in the home; and are not disposable. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative, as determined by CG. Such equipment includes, but is not limited to, crutches, hospital beds, wheel chairs, dialysis machines, glucometers, and hearing aids for children under 19. Also covered under this benefit: Jobst and TED stockings when ordered by a Physician and approved by CG.

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

- (1) **Bed related items:** bed trays, over the bed tables, bed wedge, custom bedroom equipment, mattresses, including non-power mattress, custom mattresses and posturepedic mattresses, mattress covers, pillows, or pillow covers.
- (2) **Bath related items:** bath lift, non-portable whirlpool, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats and spas.
- (3) **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), and patient lifts (mechanical or motorized). However, manual hydraulic lifts are covered if patient is two person transfer), vitrectomy chairs, and auto tilt chairs.
- (4) **Fixtures to real property:** ceiling lifts, wheelchair ramps, railings or safety grab bars.
- (5) **Car/Van modifications of any kind.**
- (6) **Air quality items:** room humidifiers, vaporizers, air purifiers, and electrostatic machines.
- (7) **Blood/injection related items:** blood pressure cuffs, centrifuges, nova pens, needle-less injectors.
- (8) **Pumps:** back packs for portable pumps.
- (9) **Equipment used for the purpose of participation in sports or other recreational activities:** including, but not limited, to orthotics, braces, splints and mouth guards.
- (10) **Other equipment:** heat lamp, heating pad, cryounits, cryotherapy machines, electronic controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adapters, Enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

N. External Prosthetic Appliances and Devices. See the Schedules of Benefits for other information regarding the Contract Year benefit allowance and Coinsurance requirements.

Coverage is provided for the initial purchase and fitting of external prosthetic appliances and devices if ordered by a Physician, available only by prescription, and necessary for the alleviation or correction of injury, sickness or congenital defects. Coverage is limited to the most Medically Appropriate and cost effective alternative as determined by CG.

External prosthetic appliances and devices shall include:

- (1) Basic limb prosthetics;
 - (2) Terminal devices such as a hand or hook;
 - (3) Speech prostheses;
 - (4) Braces, defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part. However, Copes scoliosis braces are excluded.
 - (5) Splints, defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.
 - (6) Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Only the following non-foot orthoses are covered:
 - Rigid and semi-rigid custom fabricated orthoses;
 - Semi-rigid pre-fabricated and flexible orthoses; and
 - Rigid pre-fabricated orthoses, including preparation, fitting and basic additions, such as bars and joints.
 - (7) Custom fabricated foot orthotics are covered only as follows:
 - For Members with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
 - When the foot orthotic is an integral part of a leg brace and it is necessary for the proper functioning of the brace;
 - When the foot orthotic is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of illness, injury, or congenital defect;
 - For Members with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.
 - For the treatment of plantar fasciitis following the failure of conservative medical management, including by way of example, stretching/strengthening of calf muscles, taping, strapping, nonsteriodal anti-inflammatory medications, reduced activity and physical therapy and, unless contraindicated, at least a six-week trial of a prefabricated or custom fitted orthotics.
 - For Members with acquired or congenital foot deformities when all of the following criteria apply: the deformity is the result of one of the following: symptomatic rigid flatfoot, posterior tibial tendon dysfunction, mid- or hind-foot arthritis; and the deformity is associated with significant pain that interferes with activities of daily living and there is impaired gait, balance, or mobility as a result of the condition; and conservative medical management has failed; and there is a reasonable expectation that the condition will improve through use of the orthotic device.
- The following are specifically excluded: prefabricated (including custom-fitted) foot orthoses; cranial banding and/or cranial orthoses and other similar devices are excluded, except when used postoperatively for synostotic plagiocephaly; external power enhancements or power controls for prosthetic limbs and terminal devices; orthotic shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers; orthoses primarily for improved athletic performance or sports participation; arch supports and orthoses primarily used for cosmetic rather than functional reasons. Also excluded are myoelectric prostheses peripheral nerve stimulators.
- (8) Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered.

Medically Necessary repair, maintenance, or replacement of a covered appliance is also covered.

- (9) Coverage for wigs or hairpieces prescribed by a physician for hair loss in conjunction with injury, disease, or treatment of a disease, including burns, lupus, alopecia areata with near or complete cranial hair loss, alopecia universalis, and chemotherapy or radiation therapy. Coverage is one wig or hairpiece per Contract Year. Exclusions: Male or female pattern baldness, natural or premature aging, physiological conditions or any other condition that is not considered to be Medically Necessary.

Coverage for replacement and repair of external prosthetic appliances and devices are provided when required due to reasonable wear and tear and/or anatomical change. All maintenance and repairs that result from a Member's misuse are the Member's responsibility. Replacement will be provided when anatomic change renders the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth, or replacement due to a surgical alteration or revision of the site. Coverage for replacement is limited as follows: no more than once every 24 months for persons 19 years of age and older; no more than once every 12 months for persons 18 years of age and under.

5. EXCLUSIONS AND LIMITATIONS

A. Exclusions.

Any services or supplies which are not described as covered benefits in Sections 3 and 4 (including any attached riders or endorsements) are not covered under this Health Benefits Booklet. **(Also see the Exclusions noted with the Schedules of Benefits.)**

In addition, the following are specifically excluded services or supplies:

- (1) Services and supplies deemed not Medically Necessary by CG.
- (2) Benefits for charges submitted more than 180 days after the date of service.
- (3) Blood, blood donors, or packed red blood cells when participation in a volunteer blood program is available.
- (4) Health care services received outside of the service area when the Member knows or should have known that such services would or were likely to be needed prior to leaving the service area. An example is pregnancy or maternity services after the 35th week of pregnancy.
- (5) Health care services resulting from a Member's participation in a felony, riot, insurrection or other unlawful activities.
- (6) Coverage for accidents, injuries or illnesses subject to payment by Workers' Compensation, employer's liability, or other laws of similar purpose.
- (7) Health care services for accidents, injuries or illnesses to the extent that benefits, settlement, award, or damages are received or payable (or could reasonably be expected to be received or payable) from a claim under any of the following:
 - Services that can be received under any government program, and for which the government program is the primary payer (including CHAMPUS).
 - Any federal, state, county, municipal or other government agency, including Medicare and the Veteran's Administration. This includes care for military service disabilities treatable through governmental programs if the Member is legally entitled to such care and treatment.
 - Mandatory no-fault coverage.
 - The Medicare program, if Medicare is the primary payer.

If CG provides services to a Member who is covered by one of these programs, CG is entitled to reimbursement from the Member or, if applicable, from that program for the value of such services at reasonable charges. See Sections 10 and 11. The Member agrees to actively seek to establish his or her rights to benefits from the sources noted above. If the Member refuses or fails to establish his or her rights to these benefits, CG will not be responsible for the cost of treatment. If the Member has recovered the value of Covered Services from one of these programs, the Member is required to pay CG the amount recovered.

- (8) Health care services for any accidents, injuries or illnesses, an act or omission of a person or organization, other than the Member, for which benefits, settlements, awards or damages are received or payable (or could reasonably be expected to be received or payable if a claim were made) under any federal, state, county or municipal workers' compensation, employer's liability or occupational disease laws or personal injury settlement.
- (9) Benefits payable as a result of injuries giving rise to third-party claims. See Section 10.
- (10) Intentional home deliveries of infants, and all charges related to the delivery.
- (11) Services, treatments and supplies for which no charge is normally made and/or are not Medically Necessary.
- (12) Services relating to any injury or sickness resulting from war or any act of war (declared or undeclared), or in the armed forces of any country if the Member is currently in active duty and the injury or sickness is covered by any government plan.
- (13) Services not specifically described in the Health Benefits Booklet as Covered Services.
- (14) Services, treatments and supplies received from any person in a Member's immediate family or services that are self-administered.
- (15) Services and supplies related to a non-covered service.
- (16) The cost of any service connected with hospitalization when a Member remains in the Hospital after continued hospitalization is no longer Medically Necessary as determined by CG.
- (17) Court-ordered treatment for mental health and substance abuse conditions and/or health services will be excluded if CG determines that court-ordered treatment is not Medically Necessary.
- (18) Educational testing or therapy, as determined by CG.
- (19) Dental implants for any purpose.
- (20) Air conditioners, air filters, heaters, humidifiers, and other equipment that adjusts or regulates the interior environment, even if ordered by a Participating Provider.
- (21) Foot care that is not Medically Necessary for treatment of a covered medical condition. Not Medically Necessary foot care services include, but are not limited to, care for corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints relating to the feet, toe nail trimming and supportive devices for feet, including corrective shoes.
- (22) Homemaker services, such as meals, housekeeping and personal comfort items.
- (23) Non-medical counseling services such as marriage and family therapy, sex therapy, hypnotherapy, assertiveness training, recreational, sleep, music, religious therapies and other forms of non-medical counseling, as determined by CG.
- (24) Physical examinations, immunizations and all other medical services required for travel, insurance, employment or by other third parties.
- (25) Rehabilitation services primarily intended to improve the level of physical functioning for purposes of enhanced job, athletic, or recreational performance including, but not limited to, work hardening programs, back schools, and programs of general physical conditioning.
- (26) Services and costs relating to the biological mother of an adopted child, if the biological mother is not a Member, and any services and costs relating to surrogate parenting.
- (27) Sex transformations and all procedures, services, or supplies related to sex transformations.
- (28) Cosmetic Services.
- (29) Fertility services including, but not limited to,
 - In vitro (test tube) fertilization, Gamete Intra-Fallopian Transfer (GIFT) and Zygote Intra-Fallopian Transfer (ZIFT), including all fertility-related treatment for these procedures.
 - Reversal of voluntarily-induced sterility.
 - Sperm preservation, purchase of donor sperm and any related processing costs.
 - Infertility drugs.
- (30) Therapies. Occupational, speech, physical therapy treatment, cardiac rehabilitation and chiropractic care which is long-term, or which is in excess of the coverage provided in this Health Benefits Booklet.
- (31) Vision.

- Any surgery to correct near/far sightedness, stigmatism and similar conditions.
- Vision Therapy (eye exercise therapy).

B. Limitations. For certain benefits, the rights of Members and obligations of CG under this Agreement are subject to the following limitations:

(1) **Reconstructive Surgery.** The following procedures are covered that are Medically Necessary, as determined by CG.

- For repairs of injury that occur while a Member is under Agreement;
- To correct a severe facial disfigurement or severe physical deformity, provided that reconstruction is required as a result of Medically Necessary, non-cosmetic surgery;
- To reconstruct or restore a functional part of the body following a covered surgical procedure for disease or injury which occurs while a Member is under Agreement;
- To reconstruct one or both breasts after mastectomy surgery to produce a symmetrical appearance;
- For surgery or therapy performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part including, but not limited, to microtia, amastia, and Poland Syndrome; or
- To restore or improve bodily function.

Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by CG.

(2) **Orthognathic Surgery** to correct a severe facial deformity or disfigurement that orthodontics alone cannot correct will be covered, provided that

- The deformity or disfigurement is accompanied by a documented, clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement, or
- The orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease, or
- The orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

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

(3) **Dental or Oral Surgical Care.** Benefits are limited to the following:

- Non-dental surgical and hospital procedures for those Members with congenital defects. These defects include cleft palate. Also covered are Medically Necessary surgical procedures occurring within or adjacent to the mouth or sinuses. These are limited to treatment of fractures, excision of tumors and cysts.
- When Medically Necessary and approved by CG, Hospital or licensed surgical day care facility charges and administration of general anesthesia administered by a licensed anesthesiologist or anesthesiologist will be covered for dental procedures performed on a Member who is a child under age four and is determined by a licensed dentist, in accordance with the Member's Physician, to have a dental condition of significant dental complexity requiring the dental procedure to be performed in a Hospital setting or licensed surgical day care facility; or a person who has exceptional medical circumstances or a developmental disability, which would place the person at serious risk if the dental procedure were not performed in a Hospital setting or licensed surgical day care facility.
- Removal of boney impacted wisdom teeth, subject to prior authorization by CG. Other tooth extractions are not covered.
- Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% boney support and are functional in the arch.

The following are excluded from coverage:

- Services including, but not limited to, dental treatment of the teeth, gums or structures directly supporting the teeth, crowns, caps, plates, bridges, dental x-rays, fillings, other artificial appliances, periodontal surgery, root canals, orthodontics, dental implants for any condition, casts, splints and services for dental malocclusion for any condition.
 - Temporomandibular Joint (TMJ) disorders, except that CG will cover the initial consultation to include x-ray and single arthrogram to determine if a member has TMJ. Treatment for specific TMJ disorders may be covered on a case-by-case basis if further testing yields a more specific diagnosis. Medically Necessary surgery may be covered; however, appliances and orthodontic treatments are specifically excluded as a covered benefit.
 - Soft palate reconstruction (veloplasty) to correct speech impediments.
- (4) **Weight Control/Obesity.** Surgical treatment of clinically severe obesity, as defined by the body mass index (BMI) parameters of the National Heart, Lung and Blood Institute guidelines, is covered if the services are demonstrated through peer-reviewed medical literature and scientifically based guidelines to be safe and effective for treatment of the condition and these services are approved by CG. Anti-obesity products, anorexics, diet pills, appetite suppressants (anorectics) and food products for weight control/obesity are not covered.
- (5) **Duplicate Coverage.** If a Member holds two or more group plans, benefits under the non-CG plan shall be coordinated with benefits provided under this Agreement to avoid duplicate coverage. See Coordination of Benefits, Section 11.

6. ELIGIBILITY AND ENROLLMENT

A. Eligibility

- (1) **Subscribers.** An Employee who meets all of the conditions for eligibility set by the employer and **SCHOOLCARE** is eligible to enroll. Employees must apply during an Open Enrollment Period or within 30 days after first meeting the employer's eligibility requirements.
- (2) **Family Dependents.** To be eligible as a family Dependent, a person must be either:
- (a.) The legal spouse of the Subscriber; or
 - (b.) The Subscriber's partner in a valid New Hampshire civil union or in a civil union recognized by the state of New Hampshire; or
 - (c.) An unmarried Dependent child of the Subscriber (or of the spouse/civil union partner) who resides full-time in the Subscriber's home in a parent-child relationship. This child must be :
 - (i.) Under 19 years of age; or
 - (ii.) Under 26 years of age, a resident of NH or enrolled as a student at a public or private institution of higher education, and not covered under any other health benefit plan or policy. A Dependent Child Certification Form must be filed with **SCHOOLCARE** at the time of application. Dependents enrolled as of May 31, 2010 will retain eligibility for the plan subject to the under 26 years of age requirement only; or
 - (iii.) Under 26 years of age, a full-time student, and on a medically necessary leave of absence from school for a period not to exceed the earlier of 12 months or the end of the month following the dependent's 26th birthday. Documentation and certification of the medical necessity for the leave of absence must be submitted to **SCHOOLCARE** by the student's attending physician, and shall be considered prima facie evidence of entitlement to coverage under this subparagraph. The date of the documentation and certification of the medical leave of absence shall be the date eligibility commences under this subparagraph; or

- (iv.) Any individual 19 or more years of age and continuously incapable of self-sustaining support because of a mental or physical handicap which existed prior to attaining age 19, provided that the disabled Dependent was covered by **SCHOOLCARE** at the time such coverage would have ended, and there has been no lapse of coverage. You must submit proof of the child's condition and dependence to CG within 30 days after the date the child ceases to qualify as a Dependent under subsections (i), (ii) or (iii) above. CG may, from time to time, during the next two years require proof of the continuation of the child's condition and dependence. Thereafter, CG may require such proof only once a year. Upon failure to submit required proof or when the child is no longer incapacitated, coverage with respect to the child shall cease; or
- (v.) Under 26 years of age. This applies to new hires on or after the effective date of the amendment.

As used in this section, child or children includes one or more of the following:

- Natural or legally adopted children or children placed for adoption during the period before the adoption is finalized who live with the Subscriber and are wholly supported by the Subscriber;
- Stepchildren who reside full-time in the Subscriber's home;
- Children whose home is the same as that of the Subscriber and for whom the Subscriber has been appointed permanent legal guardian by court order; and
- Children in the custody of the Subscriber pursuant to adoption proceedings.

Court-Ordered Enrollment. Notwithstanding the above, eligible family Dependents include natural or adopted children who do not reside with the Subscriber but for whom, under the terms of a court order, the Subscriber is required to provide health care coverage. Children covered pursuant to a court order will be subject to the same requirements and limits as any other family Dependent. In the event that expenses on behalf of a child covered pursuant to the terms of a court order are submitted for reimbursement by the child, the custodial parent or legal guardian, if such expenses are for Covered Services pursuant to the terms of this Health Benefits Booklet, CG shall make payment directly to the child, custodial parent or legal guardian.

- (3) Subscribers may be asked to give written proof of eligibility of Dependent children.
- (4) Grandchildren of Subscribers are not eligible for coverage unless they meet the eligibility criteria for a Dependent.
- (5) Military Personnel. Persons on active duty service in the Armed Forces are not eligible for coverage or benefits under the **SCHOOLCARE** plan.

B. Enrollment. Eligible Employees and Family Dependents may enroll in **SCHOOLCARE** in any of the following circumstances:

- (1) **Initial Eligibility.** When an Eligible Employee and his/her family Dependents initially become eligible for health coverage, if the Eligible Employee elects such coverage within 30 days.
- (2) **Application.** During the Open Enrollment Period, Employees and their family Dependents who meet the requirements of Section 6.A. may enroll in **SCHOOLCARE** if they submit complete Enrollment Applications. Members will complete such Enrollment Applications or other forms as CG and **SCHOOLCARE** may require. Members represent that all information provided is true and complete. The type of membership, e.g., individual or family, is determined by the number of individuals to be covered as Subscriber and family Dependents.
- (3) **Special Enrollment.** If the Subscriber is declining enrollment for himself or herself or for a Dependent because of other health insurance coverage, the Subscriber may in the future be able to enroll himself or herself or Dependents in **SCHOOLCARE**, provided the Subscriber requests enrollment within 30 days after the other health insurance

coverage ends. In addition, if a new Dependent is being added as a result of marriage, civil union, birth, adoption, or placement for adoption, the Subscriber may be able to enroll himself, herself and any dependents, provided that enrollment is requested within 30 days after the marriage, civil union, birth, adoption or placement for adoption. If so enrolled, the effective date of coverage will be the day of the event creating eligibility. If you do not enroll within 30 days of the event, the next opportunity for you and any eligible Dependents to enroll will be during the next Open Enrollment Period.

(4) **Enrollment Due to Loss of Prior Creditable Coverage.** If you and/or your Dependent(s) did not enroll as a Member during the Open Enrollment Period because you/or your Dependent(s) had other creditable coverage, you may be eligible to enroll for coverage under this plan if you later lose that coverage. You must submit to the Group an Enrollment Application, proof of prior coverage, and any applicable fees due within 30 days of the date that you or your Dependent(s)

- are no longer eligible for the other coverage for any reason (including separation, divorce or death of the Subscriber); or
- lost the other coverage because an employer or plan sponsor failed to pay required premium or fees; or
- completed continuation of other coverage as provided under federal or state law; or
- lost public or private coverage as a result of termination of employment or eligibility; or
- requests enrollment within 30 days after termination of such health coverage; or
- was ordered by a court to provide health coverage for an ex-spouse or minor child under a covered employer's plan and request for enrollment is made within 30 days after issuance of such court order; or
- is employed by an employer that offers multiple health coverages and the person elects a different plan during an open enrollment period.

If so enrolled, the effective date of coverage will be the first day following loss of prior creditable coverage. If these conditions are not met, or if you do not submit an enrollment application within 30 days of one of these events, the next opportunity for you or any eligible Dependent(s) to enroll will be during the next Open Enrollment Period.

(5) **Effective Dates of Coverage.** Subject to the receipt and acceptance by **SCHOOLCARE** of the applicable premium, the Member's Enrollment Application and the provisions of this Health Benefits Booklet, coverage shall become effective on the following dates:

- Except for Open Enrollment Periods, persons who meet the requirements of this Section for Members shall have coverage effective as of the day such requirements are satisfied; or
- Coverage of newborn children shall become effective at birth for a period of 30 days from the date of birth. For coverage to continue beyond the initial 30 days, the Subscriber must enroll the newborn child before the 30th day following birth.

(6) **Membership Changes.** Employees must notify their employer and **SCHOOLCARE** of any Members to be added or removed because of a Qualifying Event. All changes must be submitted in writing. Additions and/or deletions of Dependent Members must be made within 30 days of the following Qualifying Events:

- Marriage and/or divorce
- Civil union and/or dissolution of civil union
- Birth and/or death
- Adoption
- Addition of stepchildren
- Permanent legal custody
- Reinstatement of civilian status from active military personnel
- Dependent over age 19, loss of coverage due to:
 - Cease to be Subscriber's Dependent as defined in Section 2.

- Loss of other coverage due to termination of employment, termination of other coverage by someone other than the Dependent, the death of a spouse or divorce.

Subject to premiums being paid to **SCHOOLCARE**, coverage will take effect on the date of the Qualifying Event. If **SCHOOLCARE** and CG are not notified within 30 days of the Qualifying Event, membership type may be changed only on the next Open Enrollment Period.

- (7) **Eligibility for Coverage under a Qualified Medical Child Support Order.** If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a late entrant for coverage. You must notify your employer and elect coverage for that child and yourself if you are not already enrolled, within 30 days of the Qualified Medical Child Support Order being issued.

Qualified Medical Child Support Order. 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 Qualified Medical Child Support Order 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.

- (8) **Hospital or other Institutional Confinement.** If a Subscriber or Dependent is confined to a hospital or other institution on the date that he or she becomes eligible for coverage, that Member may enroll on the first day of eligibility and receive Covered Services, provided you notify CIGNA HealthCare within two days, or as soon as reasonably possible thereafter, of such confinement. When you become a Member, you agree to permit CIGNA HealthCare to assume direct coordination of your health care. If the Member fails to notify CIGNA HealthCare of this confinement, refuses to permit CIGNA HealthCare to coordinate care, or refuses to be transferred to the care of a Participating Provider or Hospital when CIGNA HealthCare determines it is Medically Appropriate, **SCHOOLCARE** will not be obligated to pay for any medical or Hospital expenses that are related to your hospitalization following the first two days after your coverage begins.
- (9) **Thirty-Day Retroactivity Limit.** **SCHOOLCARE** and CG do not permit a Member to add, delete or change Membership more than 30 days after the event, which led to the requested change. Applications must be received by **SCHOOLCARE** and CG within 30 days after the Qualifying Event. Otherwise, the next opportunity for you and any eligible Dependent(s) to enroll will be during the next Open Enrollment Period.
- (10) **Full and Accurate Completion of Enrollment Application.** Each Subscriber must fully and accurately complete the Enrollment Application. False, incomplete or

misrepresented information provided in any Enrollment Application may, at **SCHOOLCARE**'s sole discretion, cause the coverage to be null and void from its inception.

- (11) **Acceptance of Health Benefits Booklet.** When a Subscriber enrolls in **SCHOOLCARE**, either by submitting a completed Enrollment Application, or by another means acceptable to both CG and **SCHOOLCARE**, the Subscriber agrees, for himself or herself and all eligible Dependents, to abide by the terms set forth in this Health Benefits Booklet, and authorizes all providers of services to release information necessary to provide medical management services and coordinate benefits.

7. PAYMENT FOR COVERAGE

- A. **Premiums.** Only Members for whom the required Premium has been received by the Coalition shall be entitled to Covered Services under this Health Benefits Booklet, and then only for the period for which Premium is received.
- B. **Subscriber Contributions.** The Subscriber is responsible for making any contributions toward the Premium required by the employer.
- C. **Copays and Coinsurance.** Members are responsible for paying Copays and Coinsurance as provided in this Health Benefits Booklet, any endorsements or riders and the Schedule of Benefits. Copays should be paid at the time the Covered Service is received.
- D. **Deductibles.** Members are responsible for paying for Covered Services up to the Deductible amount, if any. Please review the Schedules of Benefits to determine if any Deductible applies.

8. TERM AND TERMINATION

- A. **Term.** This Health Benefits Booklet will continue in effect for one year from its effective date and from year to year thereafter subject to the termination provisions in Section 8.B. and any endorsements or riders.
- B. **Termination.** Coverage under this Health Benefits Booklet may be terminated under the circumstances listed below:
- (1) **Termination of the Agreement between the Coalition and CG.** Under the terms of the agreement between CG and the New Hampshire School Health Care Coalition, a Member's coverage will end at midnight on the last day the agreement remains in effect.
 - (2) **Termination of the Agreement between the Coalition and the Employer.** A Member's coverage will end at midnight on the last day the agreement remains in effect. Failure by the employer to notify Members of termination of the agreement shall not cause coverage to be continued beyond the effective date of termination.
 - (3) **Termination of Member Coverage.**
 - For nonpayment of Premium by the employer to the Coalition on behalf of the Subscriber and Dependents.
 - Membership ends on the date when the Member is no longer eligible for coverage as a Subscriber or Dependent.
 - For Cause:
 - Coverage may be terminated for misrepresentation on the Enrollment Application.
 - If a Member permits another person to use their Identification Card, CG or the Coalition may reclaim the Identification Card and terminate membership.

- Failure to cooperate in Coordination of Benefits or Right of Recovery under Sections 10 and 11.
 - If a Member uses their Identification Card to obtain benefits for which he or she is not eligible.
 - If a Member engages in conduct that disrupts or interferes with CG or Coalition operations.
 - Other failure by a Member to comply with the terms and conditions of this Health Benefits Booklet, including any endorsements or riders attached hereto.
- C. Effect of Termination.** No benefits will be provided under this Health Benefits Booklet for services rendered after the date that coverage would otherwise terminate, including services rendered in connection with an injury or illness that commences prior to the effective date of termination.
- D. Reinstatement.** If a Member's coverage is terminated for any reason, and that Member then applies for a reinstatement of such coverage at any time other than a regularly scheduled Open Enrollment Period, the Coalition and CG may, in its sole discretion, choose to reinstate the Member subject to such terms and conditions as the Coalition and CG may specify.
- E. Notice of Credible Coverage.** Under the Health Insurance Portability and Accountability Act (HIPAA), when the Coalition is notified by your employer that you and/or your Dependents have terminated coverage, CIGNA HealthCare will automatically generate a Certificate of Creditable Coverage. This Certificate will be mailed to the Subscriber and/or Dependents at the last known address on file. Also, you or someone on your behalf may request a Certificate within 24 months after coverage ceases by contacting CIGNA's Customer Service Department at 1-800-244-6224, or by contacting the New Hampshire School Health Care Coalition at 1-800-562-5254. This Certificate verifies your coverage under the **SCHOOLCARE** program for the length of time you and/or your Dependents were enrolled in the plan. Obtaining this Certificate is very important in preserving your rights to obtain health insurance coverage without limitations or waiting periods for pre-existing conditions.

9. CONTINUATION OF COVERAGE

Upon termination of employment or **SCHOOLCARE** coverage, a Member may be eligible for Continuation of Coverage for up to 36 months.

- A. Eligibility.** Members should contact their employer about the potential Continuation of Coverage if the Subscriber or a family Dependent becomes ineligible to continue participation in the **SCHOOLCARE** health benefit plans. A Subscriber or family Dependent may lose eligibility if the Subscriber's employment ends, there is a reduction in the Subscriber's hours, the Subscriber dies, divorces, legally separates, becomes disabled, or a family Dependent exceeds the age limit for coverage of dependent children.

Under COBRA, coverage may be continued for 18 months if coverage ends due to termination of the Subscriber's employment or reduction of the number of Subscriber's hours. The 18-month continuation period may be extended up to 29 months if the Member is determined to be disabled under Title XVI of the Social Security Act at the time the Member became eligible for continued group coverage, or if the Member becomes disabled within 60 days of the effective date of the continued group coverage. If disabled, the Member may apply for extended coverage by submitting the Social Security Administration's Disability Eligibility letter to **SCHOOLCARE**. This must be done within 60 days of the Social Security Administration's determination that the Member is disabled and prior to the end of the 18-month continuation period.

Also, whenever an individual becomes ineligible for continued participation under the **SCHOOLCARE** benefit program for any reason, including death, except dismissal for gross misconduct, coverage shall be available to the individual, the surviving spouse/civil union partner and the Dependents covered by **SCHOOLCARE** for an extension period of:

- (1) 18 months; or
- (2) 29 months in the case of a Member who is determined under Title II or XVI of the Social Security Act to have been disabled within the first 60 days of the date the Member becomes ineligible for continued participation in the **SCHOOLCARE** benefit program; or
- (3) 36 months in the case of:
 - the death of the covered Subscriber;
 - the divorce or the legal separation of the covered Subscriber from his or her spouse/civil union partner;
 - the covered Subscriber becoming entitled to benefits under Title XVIII of the Social Security Act, or the covered Member's becoming entitled to benefits under Title XVIII of the Social Security Act within the 18-month continuation period in subparagraph (1); or
 - a Dependent child ceasing to be a Dependent child; or
- (4) When the surviving spouse/civil union partner, divorced spouse/civil union partner or legally separated spouse/civil union partner of a Subscriber is age 55 or older, in the case of the death of the Subscriber, or the divorce or the legal separation of the Subscriber from the Subscriber's spouse/civil union partner, then the extension period shall be continued until the surviving spouse/civil union partner, divorced spouse/civil union partner or legally separated spouse/civil union partner becomes eligible for participation in another employer-based group plan or becomes eligible for Medicare, or until remarriage or entry into another marriage/civil union of either the Member spouse/civil union partner or the former spouse/civil union partner, whichever occurs first.

- B. Election of Continuation Coverage and Premiums.** A Member should be notified by the Member's employer of his or her right to elect Continuation Coverage following an event that would otherwise cause a loss of **SCHOOLCARE** coverage. A Member who experiences a change in family status, such as a divorce or legal separation, or a child becoming too old for Dependent coverage should contact the Member's employer to ensure that the Member's right to elect Continuation Coverage is promptly processed.

Once the Member is notified of the option to elect Continuation Coverage, the notice will state the period of time in which the Member must elect to purchase the coverage. A Member must pay the Premiums for Continuation Coverage from the date of the event which caused the loss of coverage in accordance with the instructions and the time limitation contained in the notice.

Should the Member or Dependents elect to continue participation in **SCHOOLCARE**, the Member or Dependents shall be responsible for payment of Premiums, which may include an administrative fee not to exceed two percent of the monthly Premium.

Any divorced spouse/civil union partner or legally separated spouse/civil union partner who is responsible for making a portion of or full payment for continued coverage shall notify the employer and **SCHOOLCARE** in writing within 30 days of the decree of divorce, separation or dissolution of the civil union that coverage under this subparagraph is requested.

Any Subscriber who is responsible for making a portion of or full payment for continued coverage shall likewise notify the employer and **SCHOOLCARE** in writing within 30 days of the decree of divorce, separation or dissolution of the civil union that coverage under this subparagraph is requested.

SCHOOLCARE shall have the right to terminate coverage for a former Dependent spouse or civil union partner who is receiving coverage under this subparagraph if any payment for the coverage is not received from the former Dependent spouse/civil union partner within 30

days of the date the Premium payments are due. If any payment for the coverage for which the Subscriber is responsible is not received from the Subscriber within 30 days of the date the Premium payments are due, **SCHOOLCARE** shall have the right to terminate coverage for a former Dependent spouse/civil union partner; however, no such termination shall occur without 30 days' prior notice to the former Dependent spouse/civil union partner, during which time the former Dependent spouse/civil union partner shall be given an opportunity to make the payments due.

C. Termination of Continuation Coverage. Continuation of Coverage will automatically terminate under the following circumstances:

- (1) The employer no longer provides group health care benefits to any of its Eligible Employees or Members;
- (2) The employer no longer offers **SCHOOLCARE** benefits to its employees;
- (3) CG or **SCHOOLCARE** terminates this health benefits program;
- (4) The Member fails to pay his/her Premiums. Payment is due on the first day of the month. If not received by the end of the month, termination will result;
- (5) The Member becomes covered under another group health care plan;
- (6) The Member becomes entitled to benefits under the Medicare Program; or
- (7) The Member becomes ineligible for coverage due to failure to comply with the terms and conditions of this Health Benefits Booklet, including any endorsements or riders.

D. Disability Continuation. Special rules regarding coverage periods, Premiums, notices and terminations apply to individuals who are disabled under the terms of Title II or Title XVI of the Social Security Act at the time of a Qualifying Event involving termination of employment or reduction of hours. These rules are as follows:

- (1) **Maximum Coverage Period.** An individual eligible for Continuation Coverage under this Section 9.D. may continue coverage up to 29 months from the date of the Qualifying Event, provided that the individual provides notice of such eligibility to the Employer and **SCHOOLCARE** before the end of the first 18 months of Continuation Coverage.
- (2) **Increased Premium Payments.** After the first 18 months of continuation coverage, Premiums for disabled individuals may not exceed 150% of the total Premium charged for such period of coverage for similarly situated Members to whom a Qualifying Event has not occurred.
- (3) **Termination.** The maximum coverage period for persons eligible for Continuation Coverage under this Section 9.D. is 29 months. In addition to the grounds set forth for termination in Section 9.C. (except for expiration of maximum coverage period), after the first 18 months of Continuation Coverage, a qualified beneficiary may be terminated effective as of the first day of the month that is more than 30 days after the date of a final determination that the individual is no longer disabled.
- (4) **Notice Requirements.** In order to be eligible for the additional period of Continuation Coverage available under this Section, the qualified beneficiary must notify **SCHOOLCARE** of his or her disabled status prior to the end of the first 18 months of Continuation Coverage. The qualified beneficiary must also notify **SCHOOLCARE** within 60 days of any final disability determination, and within 30 days of any determination that the individual is no longer disabled.

E. Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

USERRA sets requirements for continuation of health coverage and re-employment in regard to military leaves of absence. These requirements apply to medical coverage for the Subscriber and Dependents. If an Employee voluntarily or involuntarily leaves employment to undertake military service, the Employee and Dependents have the right to elect continuation of existing employer-based health plan coverage. Premiums must be paid by the Employee during this leave of absence. The employer may charge up to 102% of the total premium. **SCHOOLCARE** coverage will end upon the earliest of the following:

- (1) 24 months from the last day of employment with the employer;
- (2) The day after the Employee fails to apply or return to work; and
- (3) The date the **SCHOOLCARE** policy cancels.

- (4) If the Employee does not elect to continue coverage under USERRA during the military leave of absence, he or she has the right to be reinstated to the employer's health plan when reemployment occurs, generally without any waiting periods or exclusions for pre-existing conditions, except for service-connected illnesses or injuries. If an injury or illness occurs or is aggravated during the military leave, any and all benefit limitations noted in this Health Benefits Booklet will apply. To be eligible for reinstatement, the Employee must have given the employer advance written or verbal notice of the military service leave, and the duration of all military leaves while employed by the current employer does not exceed five years.

10. SUBROGATION, REIMBURSEMENT AND RIGHT OF RECOVERY

The benefits payable hereunder as a result of any illness or injuries that give rise to a claim by any Member (in this Section, the term "Member" shall include a Member's Dependents enrolled in **SCHOOLCARE** and the estate, personal representative or beneficiary of the Member or of such Dependents) against a third party tortfeasor or against any person or entity because of the action or inaction of such tortfeasor, person or entity (a "Personal Injury Claim") are excluded from coverage under the **SCHOOLCARE** program. **SCHOOLCARE** also does not provide benefits to the extent that there is other coverage under non-group medical payments (including auto) or medical expense-type coverage to the extent of that coverage. In the event a Member suffers an illness or injury as a result of any set of facts that could give rise to a Personal Injury Claim, **SCHOOLCARE** will provide benefits, otherwise payable under this program, to or on behalf of a Member only on the following terms and conditions:

- A. Such benefits shall be subrogated to all of the Member's rights of recovery against any person or entity to the extent of the benefits provided. The Member shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Member shall do nothing after loss to prejudice such rights. The Member hereby agrees to cooperate with the New Hampshire School Healthcare Coalition (the "Coalition"), CG or any representatives of the Coalition or CG in completing such forms and in giving such information as the Coalition, CG or its representatives deem necessary to fully investigate the incident and prosecute its claim.
- B. The Member (or any attorney, agent or trustee on the Member's behalf) shall reimburse **SCHOOLCARE** from the proceeds of any recovery in a Personal Injury Claim from any third party, whether by settlement, judgment, or otherwise, for benefits paid by **SCHOOLCARE** to or on behalf of the Member. **SCHOOLCARE**'s share of any recovery shall not be reduced because the Member has not received the full damages claimed unless **SCHOOLCARE** agrees in writing to such a reduction. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph A, but only to the extent of the benefits provided to the Member by the **SCHOOLCARE** program.
- C. The Member agrees to grant, and hereby grants, to the Coalition and CG (acting on behalf of **SCHOOLCARE**) an equitable lien on the proceeds of any recovery in a Personal Injury Claim from any third party, whether by settlement, judgment or otherwise, intended for, payable to, or received by the Member or any attorney, agent or trustee on the Member's behalf. The Member hereby consents to said equitable lien and agrees to take whatever steps are necessary to assist the Coalition or CG in securing and perfecting said lien. The Member agrees that said lien shall constitute a charge upon and a property interest in the proceeds of any recovery in a Personal Injury Claim and the Member and his/her representatives agree to hold the proceeds of any Personal Injury Claim recovery in trust for the benefit of **SCHOOLCARE** and CG to the extent of any benefits paid on behalf of the Member.
- D. The Member agrees to assign, and hereby assigns, to the Coalition and CG (acting on behalf of **SCHOOLCARE**) the proceeds of any recovery in a Personal Injury Claim from any third party, whether by settlement, judgment or otherwise, intended for, payable to, or received by the Member or any attorney, agent or trustee on the Member's behalf in an amount equal to

the benefits paid to or on behalf of the Member. This assignment is and shall be binding on any attorney who represents the Member (whether or not an agent of the Member) and on any insurance company or other financially responsible party against whom a Member may have a claim, provided said attorney, insurance company or other party has been notified by the Coalition, **SCHOOLCARE**, CG or its agents of this assignment.

- E. The foregoing subrogation and reimbursement rights, equitable lien, and assignment provisions apply to any recoveries made by the Member as a result of a Personal Injury Claim, including but not limited to the following:
- (1) Payments made directly by the third party tortfeasor, or any insurance company on behalf of the third party tortfeasor, or any other payments on behalf of the third party tortfeasor.
 - (2) Any payments or settlements or judgment or arbitration awards paid by any insurance company under the uninsured or underinsured motorist coverage of any insurance policy, whether on behalf of a Member or other person.
 - (3) Any other payments, from any source, designed or intended to compensate a Member for injuries sustained as the result of negligence or alleged negligence or any intentional act of a third party.
 - (4) Any workers' compensation award or settlement.
 - (5) Any recovery made pursuant to no-fault insurance.
 - (6) Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.
- F. No adult Member hereunder may assign any rights that he or she may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult Member without the prior, written consent of the Coalition, **SCHOOLCARE** or CG. **SCHOOLCARE's** right to recover (whether by subrogation, reimbursement or assignment) shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- G. No Member shall make any settlement that specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by **SCHOOLCARE** or CG.
- H. **SCHOOLCARE's** foregoing rights of recovery shall not be defeated or reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat **SCHOOLCARE's** recovery rights by allocating the proceeds of a Personal Injury Claim exclusively to non-medical expense damages.
- I. No Member hereunder shall incur any expenses on behalf of **SCHOOLCARE** in pursuit of **SCHOOLCARE's** rights hereunder; specifically, no court costs or attorneys' fees may be deducted from **SCHOOLCARE** or CG's recovery without the prior, written consent of the Coalition, **SCHOOLCARE** or CG. **SCHOOLCARE's** rights hereunder shall not be defeated by any so-called "Fund Doctrine," or "Common Fund Doctrine," or "Attorney's Fund Doctrine."
- J. **SCHOOLCARE** and CG shall be entitled to recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Member, whether under comparative negligence or otherwise.
- K. The benefits under the **SCHOOLCARE** program are secondary to any coverage under no-fault or similar insurance.
- L. In the event that a Member shall fail or refuse to honor its obligations hereunder, then the Coalition, **SCHOOLCARE** or CG shall be entitled to recover any costs incurred in enforcing the terms hereof, including but not limited to attorney's fees, litigation, court costs, and other expenses.

- M. The Member agrees that any breach of this Section by the Member would cause irreparable and substantial harm to **SCHOOLCARE** and that no adequate remedy at law would exist. In addition, the Member agrees that **SCHOOLCARE** is providing benefits under this Section contingent upon and in reliance upon the Member's understanding that **SCHOOLCARE** and CG have an equitable lien on the proceeds of any settlement. Further, the Coalition and CG (on behalf of **SCHOOLCARE**) shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of this Section, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief. **SCHOOLCARE** shall be entitled to terminate from coverage any Member who fails to comply with the terms of this Section or who fails to cooperate with the Coalition, **SCHOOLCARE** or CG in their efforts and investigations under this Section.

11. COORDINATION OF BENEFITS (COB)

A. Applicability.

This Coordination of Benefits (COB) provision applies when a Member or the Member's covered Dependent has health care coverage under more than one plan. "Other Coverage" and "Plan" are defined in Section 11.B. If you are covered by more than one Plan, you should file all claims with each Plan.

If this COB provision applies, the Order of Benefit Determination Rules should be looked at first. These rules establish whether **SCHOOLCARE** benefits are determined before or after those of Other Coverage. **SCHOOLCARE** benefits will not be reduced when, under the Order of Benefit Determination Rules, **SCHOOLCARE** determines its benefits before Other Coverage. However, **SCHOOLCARE** benefits may be reduced when, under the Order of Benefit Determination Rules, the Other Coverage determines its benefits first. This reduction is described in Section 11.D, "Effect on Covered Services under the **SCHOOLCARE** Plan."

B. Definitions.

- (1) Other Coverage is any of the following that provides benefits or services for medical care or treatment (including dental):
- Group insurance or group-type coverage, whether insured or self-insured. This includes prepayment, group practice or individual practice coverage, but not student accident or student accident and health coverage, for which the student or parent pays the entire premium; or
 - A closed panel plan that provides health benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits received from providers outside the panel, except in cases of emergency; or
 - Coverage under Medicare and other governmental benefits as permitted by law, except Medicaid and Medicare supplemental policies; or
 - Medical benefits coverage of group, group-type, and individual automobile policies. This includes "no fault" and traditional "fault" type contracts, which will be considered primary for any automobile accident-related medical expenses. Uninsured motorist insurance and automobile medical payment benefits shall be considered part of any automobile insurance.

Each contract or other arrangement for coverage under Section B. (1) above shall be treated as a separate Plan. Also, if a Plan has two parts and only one part has Coordination of Benefit rules, each of the parts shall be treated as a separate Plan.

- (2) Primary Plan is the Plan that determines and provides or pays its benefits first, without taking into consideration the existence of any other Plan.
- (3) Secondary Plan is the Plan that determines and may reduce its benefits after taking into consideration the benefits provided or paid by the Primary Plan. A Secondary Plan may

also recover the Reasonable Cash Value of any services it provided to you from the Primary Plan.

The Order of Benefit Determination Rules state whether **SCHOOLCARE** is the Primary Plan or Secondary Plan. When **SCHOOLCARE** is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When **SCHOOLCARE** is the Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

- (4) Allowable Expense means a necessary, Reasonable and Customary Charge for a Covered Service, when the expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service rendered will be considered both an Allowable Expense and benefit paid.

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

- An expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private hospital room and no Plan provides coverage for more than the semi-private room, the difference in cost between the private and semi-private room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of Reasonable and Customary fees, any amount in excess of the highest Reasonable and Customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of Reasonable and Customary fees, and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- When benefits are reduced under a Primary Plan because a Member does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those relating to pre-certification of admissions and services, and preferred provider arrangements.

- (5) Claim Determination Period means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Health Benefits Booklet, or any part of a year before the date this COB provision or a similar provision takes effect.

- (6) Reasonable Cash Value means an amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service within the immediate geographic area where the service is rendered under similar or comparable circumstances.

C. Order of Benefit Determination Rules.

- (1) **General.** A Plan that does not have a Coordination of Benefits rule consistent with this section shall always be the Primary Plan. If the other Plan does have a COB rule consistent with this section, the first of the following rules that applies to the situation is the one to use.

- (2) **Rules.** **SCHOOLCARE** will determine the order of benefits using the first of the following rules which applies:

- **Subscriber:** The Plan that covers you as a Subscriber or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan. If you are covered as a Subscriber under two Plans, the benefits of the Plan that covered you longer are determined before those of the Plan which covered you for a shorter period of time.
- **Dependent Child/Parents Not Separated or Divorced:** If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the

Plan which covers the parent whose birthday falls first in the calendar year as a Subscriber or employee.

- **Dependent Child/Separated or Divorced Parents:** If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First, the Plan of the parent with custody of the child;
 - Then, the Plan of the spouse of the parent with custody of the child;
 - Then, the Plan of the parent not having custody of the child.
 - Finally, the Plan of the spouse of the parent not having custody of the child.However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. (A copy of the court decree must be submitted to CG when a claim is received that requires verification of the terms of the decree in order to accurately determine the order of benefit payment.)
- **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan that covered a Member or Subscriber longer are determined before those of the Plan that covered that person for the shorter time.

(3) **Joint Custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Section 11.C. (2), Dependent Child/Parents Not Separated or Divorced.

(4) **Medicare. SCHOOLCARE** is primary and Medicare is secondary under the following conditions:

- When a Member is age 65 or older and has **SCHOOLCARE** coverage through either his or her own employment or through the employment of a spouse.
- When a Member is under age 65 and has **SCHOOLCARE** coverage through either his or her own active employment or through the active employment of a family member, and is entitled to Medicare due to a disability (other than End Stage Renal Disease (ESRD)).
- When a Member is eligible for Medicare solely or partly on the basis of ESRD and has **SCHOOLCARE** coverage through either his or her own employment or through the employment of a spouse, **SCHOOLCARE** is primary for the first 30 months after the Member becomes eligible for Medicare.

(5) **CG Guidelines.** When other insurance has been determined as the primary payer, CG coverage guidelines must still be satisfied.

D. Effect on Covered Services under the SCHOOLCARE Plan.

If **SCHOOLCARE** is determined to be the Secondary Plan, it may reduce benefits by not paying more than 100% of the Allowable Expenses, or more than what **SCHOOLCARE** would have paid in the absence of other coverage, whichever is less.

E. Right to Receive and Release Needed Information.

Certain information is needed to apply these COB rules. CG has the right to decide what information it needs, provided the information is related to the claim. It may get information from, or give them to any other organization or person with a legitimate interest in the claim. CG need not tell, or get the consent of any person to do this. Each person claiming benefits under the **SCHOOLCARE** plan must give CG any facts it needs to coordinate your benefits pursuant to Section 11 of this Health Benefits Booklet.

F. Facility of Payment.

A payment made under another plan may include an amount that should have been paid by **SCHOOLCARE**. If it does, CG may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid by **SCHOOLCARE**. CG will not have to pay that amount again. The term “payment made” means the Reasonable Cash Value of the benefits provided in the form of services.

G. Right of Recovery.

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

- (1) From any person to, or for whom, or with respect to whom such services or payments were made;
- (2) Insurance companies, health care plans, or
- (3) Other organizations.

The amount of the payments made includes the Reasonable Cash Value of any benefits provided in the form of services or supplies. If requested by **SCHOOLCARE**, the Member shall execute documents **SCHOOLCARE** determines necessary to secure its rights under these COB provisions.

12. CLAIMS PROCEDURES

A Participating Provider shall in most instances submit all claim forms and bills directly to CG for the Covered Services. CG will pay the Participating Provider directly. A Member receiving bills for Covered Services in connection with Emergency Services outside the service area should submit bills directly to CG for payment. For plans with out-of-network benefits where the Member is required to pay at the time of service, an itemized statement and a completed claim form must be submitted by the Member directly to CG within 180 days from the date of service. CG has the right to recover from the Participating Provider or Member any benefit payments made in error. Claim forms are available on the CIGNA HealthCare Web site at www.cigna.com, or you may call Member Services at the toll-free number on the reverse of your ID card.

13. APPEAL PROCEDURES

When You Have a Complaint or Appeal: For the purposes of this section, any reference to “you”, “your” or “Member” also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted. “We” refers to CIGNA HealthCare or CG, the claims administrator for the **SCHOOLCARE** program.

We want you to be satisfied with the care you receive. That’s why we’ve established a process for addressing your concerns and solving your problems.

Start with Member Services

We’re here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call us at our toll-free number and explain your concern to one of our Customer Services representatives. You can also express that concern in writing. The Customer Services Toll-Free Number and the appropriate address appear on your CIGNA HealthCare ID card. We’ll do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we’ll get back to you as soon as possible, but in any case, within 30 calendar days. If you are not satisfied with the results of a coverage decision, you can start the formal appeals procedure described below.

Internal Appeals Procedure

CG has a two-step appeal procedure for coverage decisions. To initiate an appeal, you must submit a request in writing at the address shown below within 90 days of receipt of an adverse benefit determination (i.e. denial notice). You should state the reason why you believe your appeal should be approved and include any information supporting your position. If you are

unable or choose not to write, you may ask to register your appeal by calling the toll-free number on your Identification Card.

CIGNA HealthCare
National Appeals Unit
PO Box 5225
Scranton, PA 18505-5225.
Telephone: 1-800-244-6224

In addition, at any point during the Appeals Procedure, you may request assistance from a **SCHOOLCARE** representative by calling 1-800-562-5254.

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 Medically Appropriate services for benefits covered by the **SCHOOLCARE** plan will be considered by a health care professional. You and your Physician may submit any documentation to support your appeal. We will respond in writing with a decision within 15 calendar days after receipt of your appeal of a pre-service or concurrent coverage determination, or within 30 calendar days after receipt of your appeal of a post-service coverage determination. If more time or information is needed to make the determination, we will notify you in writing and request an extension of up to 15 calendar days and specify the additional information needed to complete the review.

You may request that the appeal process be expedited if (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or, in the opinion of your Physician, would cause you severe pain, which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient hospital stay. CG's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within seventy-two (72) hours, followed-up in writing.

If you do not receive a timely response to your Level One Appeal, you may proceed directly to Level Two.

Level Two Appeal

If you are dissatisfied with our Level One Appeal decision, you may request a second review within 30 calendar days. To initiate a Level Two Appeal, follow the same process required for a Level One Appeal. If the appeal concerns Medical Necessity or Medically Appropriate services for benefits covered by the **SCHOOLCARE** plan, a Physician Reviewer or committee of health care professionals who were not involved in the initial denial or Level One Appeal will review all information submitted by you and your doctor and respond in writing with a decision within 15 calendar days after receipt of your Level Two Appeal of a pre-service or concurrent coverage determination, or within 30 calendar days after receipt of your Level Two Appeal of a post-service coverage determination. CG will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by CG's Physician Reviewer. 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 the additional information needed to complete the review.

You may request that the appeal process be expedited if (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality, or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient hospital stay. CG's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within seventy-two (72) hours, followed-up in writing.

If you do not receive a timely response to your Level Two Appeal, you may proceed to directly to an Independent External Review.

Notice of Benefit Determination

At the conclusion of each level of appeal, a Notice of Benefit Determination will be sent to you. Every notice of determination will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific benefit provisions on which the determination is based; (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information; (4) a statement describing any voluntary appeal procedures offered by **SCHOOLCARE**; and (5) 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 (6) an explanation of the scientific or clinical judgment for a determination that is based on Medical Necessity, Experimental treatment or other similar exclusion or limitation.

Independent External Review

General Information

An external appeal is a request that you make for an independent review of a denial of services by CG. You must make this request in writing and submit all documentation to the address above within 90 days of receiving the Level Two decision. CG will then forward all documentation to an Independent Review Organization (IRO). You and your Physician may submit additional documentation or materials to further support your appeal. Independent Review Organizations are composed of persons with a medical background, who are not employed by CIGNA HealthCare, CG, the Coalition, or **SCHOOLCARE**, or any of its affiliates. A decision to use the voluntary level of appeal will not affect your rights to any other **SCHOOLCARE** benefits. There is no charge for you to initiate an Independent Review. CIGNA HealthCare, CG, the New Hampshire School Health Care Coalition and **SCHOOLCARE** will abide by the decision of the IRO.

To be eligible for Independent External Review, the following conditions must be met:

- The service that is the subject of the appeal request must be a covered benefit under the terms of this Health Benefits Booklet, including any written endorsements or riders attached hereto, or at least something that could be a covered benefit in some circumstances, and
- Previous denials have been based on Medical Necessity or Medical Appropriateness. (Administrative, eligibility, benefit coverage limits, or exclusions are not eligible for External Review under this process.), and
- You must have completed the Internal Appeal process provided by CG and received a final decision, unless CG has failed to respond to the Level One or Level Two appeal in a timely manner, and
- The cost to you for the service that CG has denied must amount to at least \$400 in a 12-month period, and
- Your request for an Independent External Review must not be for the purpose of pursuing a claim of health care provider malpractice, professional negligence, or other professional fault.

You may designate anyone you like, including your treating health care provider, to represent you.

Filing the External Appeal

Please be sure to include all of the following with your appeal:

- A signed Election Form-“Request to Elect External Review.”
- A copy of the letters from CG denying your request at the first and second levels of the appeal process.
- Any medical records or statements from your treating health care providers, or other information that you would like the IRO to consider in reviewing your case.

The IRO will render a decision within 30 days of receipt of your request and all relevant documentation, except in cases of an Expedited External Review. (See below.)

Expedited External Review

You may request Expedited External Review if the time frame for standard review would (a) seriously jeopardize your life, health or ability to regain maximum functionality or, in the opinion

of your Physician, would cause you severe pain, which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient hospital stay. CG's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. Expedited review decisions by the IRO will be made within 72 hours of receipt of the necessary information to make a determination.

What Happens When An Independent Review Organization Makes Its Decision?

If your appeal was expedited, in most cases you and CG will be notified of the IRO's decision by telephone or fax. Written notification will follow. If your appeal was not expedited you and CG will be notified in writing.

The decision of the Independent Review Organization is binding on **SCHOOLCARE**, the New Hampshire School Health Care Coalition, CIGNA HealthCare and CG. The decision is binding on you as well, except that it does not prevent you from pursuing any other claim or remedy you may have under federal or state law. However, the Member agrees that other legal remedies may only be pursued after all appropriate appeal levels under this procedure have been exhausted.

14. CIGNA HEALTHCARE CONFIDENTIALITY POLICIES. Information from a Member's medical records and information about a Member's doctor-patient and hospital-patient relationships shall be kept confidential in accordance with the Confidentiality and Disclosure Policy of CIGNA HealthCare*. Under Section 14, the following words refer to CIGNA HealthCare: "we", "our", or "us".

CIGNA HealthCare's Confidentiality Policies*

To help you better understand how CIGNA HealthCare protects your confidentiality, we are providing you with answers to some common questions about our confidentiality policies.

What Types of Information Do We Receive?

We receive information needed to administer your plan, including from plan participants who apply for coverage or who submit a claim, and information from medical providers and Employers.

How Do We Protect Confidential Information?

CIGNA HealthCare employees and organizations who act on behalf of CIGNA HealthCare are required to keep plan participants' personal information confidential. Here is what we are doing to help ensure this policy is followed:

1. We have established a CIGNA HealthCare privacy program office, which is responsible for monitoring our compliance with confidentiality policies, and for educating the organization on this important topic.
2. Whenever possible, we provide only aggregate information that does not identify any individual. If we need to share individually identifiable information, we have policies that protect confidentiality.
3. Our employees may not disclose information to other employees except when it is needed to conduct CIGNA HealthCare business.
4. We require a written agreement from companies and organizations, including plan sponsors, who receive confidential information from us. These companies and organizations agree that they will use any individually identifiable information only to administer the benefits plan in accordance with applicable laws.
5. Sometimes we require a plan participant's written authorization before we disclose confidential information. For example, a request from a research organization or from a plan participant's attorney would require an authorization signed by the plan participant. If the request were for information about a minor or an adult who was unable to exercise rational judgment or to give informed consent, we would require an authorization from the plan participant's parent or legal guardian.
6. We protect the confidentiality of information for former plan participants, just as we do for current plan participants.

We have also taken the following steps to help make sure CIGNA HealthCare facilities have policies to protect confidential information:

1. Access to our facilities is limited to authorized personnel.
2. CIGNA HealthCare locations that maintain confidential information have procedures for accessing, labeling and storing confidential records.
3. We have additional policies and procedures to protect confidential information when CIGNA HealthCare provides medical treatment in one of our affiliated medical facilities.

What Types Of Information Do We Disclose, and to Whom?

CIGNA HealthCare will not release confidential information unless it is necessary to administer the benefits plan or to support CIGNA HealthCare programs or services, such as our care management and wellness programs. We may disclose information relating to claims and the processing of claims to:

1. Medical providers;
2. Plan administrators;
3. Insurers that provide reinsurance or excess (Stop Loss) insurance;
4. CIGNA HealthCare affiliated companies such as Intracorp, CIGNA Behavioral Health, Inc. CIGNA Dental companies and CIGNA Tel-Drug companies;
5. Regulatory agencies (such as departments of insurance) and accreditation organizations (such as the National Committee for Quality Assurance);
6. Courts or attorneys who serve us with a subpoena;
7. New insurers or claim administrators who assume responsibility for administering the benefit plan;
8. Companies that assist CIGNA HealthCare in recovering overpayments;
9. Companies that pay claims or perform utilization review services for CIGNA HealthCare;
10. Companies that assist CIGNA HealthCare in recovering benefits that were paid for claims incurred as a result of third-party negligence; and
11. Companies not affiliated with CIGNA HealthCare that perform other services for CIGNA HealthCare.

How Can Plan Participants Access Their Confidential Information?

Plan participants have a right to review their medical records and other personal information and can submit a written request for those records or information to the Physician or other health care provider who created the record or to CIGNA HealthCare. CIGNA HealthCare strives to make sure that information is accurate and complete. If a plan participant finds an error and wishes to correct it, he or she can contact the Provider who created the record or CIGNA HealthCare.

How Do We Let Plan Participants Know About Our Confidentiality Policy?

Often, plan participants are informed about our confidentiality policies and practices during enrollment. However, even if that is not practical (for example, when plan participants enroll by telephone), we strive to inform all prospective and current plan participants about our confidentiality policies and practices through plan and policy documents, newsletters and pre-enrollment materials.

**CIGNA companies are providers of employee benefits, health care coverage, insurance products, investment management and financial services to businesses and individuals worldwide. "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Intracorp, CIGNA Behavioral Health, Inc., and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. "CIGNA Dental" refers to the following operation subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc. and its operating subsidiaries. "CIGNA Tel-Drug" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C., which are also operating subsidiaries of CIGNA Corporation.*

15. SCHOOLCARE NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY SCHOOLCARE AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. The words “we” and “our” refer to SCHOOLCARE.

Protected Health Information (PHI) is information, including demographic information, that may identify you and that relates to health care services provided to you, the payment for health care services provided to you, or your physical or mental health condition, in the past, present or future. This Notice of Privacy Practices (the “Notice”) describes how **SCHOOLCARE** may use and disclose your PHI. It also describes your rights to access and control your PHI.

As a health plan, **SCHOOLCARE** is required by federal law to maintain the privacy of PHI and to provide you with this Notice of our legal duties and privacy practices. The New Hampshire School Health Care Coalition (the “Coalition”) administers **SCHOOLCARE** and is responsible for ensuring **SCHOOLCARE**'s compliance with federal law.

We are required to abide by the terms of this Notice, but reserve the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all PHI that we are maintaining at that time. If a change is made to this Notice, a copy of the revised Notice will be provided to all individuals covered under **SCHOOLCARE** at that time.

PERMITTED USES AND DISCLOSURES

Treatment, Payment and Health Care Operations

Federal law allows a health plan to use and disclose PHI, for the purposes of treatment, payment and health care operations, without your consent or authorization. Examples of the uses and disclosures that **SCHOOLCARE**, as a health plan, may make are listed below:

1. Treatment. Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. **SCHOOLCARE** does not provide treatment.
2. Payment. Payment refers to the activities of a health plan in collecting premiums and paying claims for health care services you receive. Examples of uses and disclosures under this section include the sending of PHI to an external medical review company to determine the medical necessity or experimental status of a treatment; sharing PHI with other insurers to determine Coordination of Benefits or settle Subrogation claims; providing PHI to a utilization review company for pre-certification or case management services; providing PHI in the billing, collection and payment of premiums and fees to **SCHOOLCARE** vendors such as third party administrators and stop-loss or excess insurance carriers; and sending PHI to such carriers to obtain reimbursement of claims paid under the **SCHOOLCARE** health plan. **SCHOOLCARE** will not generally conduct these types of activities directly, but will instead utilize the services of its Business Associate, Connecticut General Life Insurance Company (“Connecticut General”). Accordingly, **SCHOOLCARE** will not ordinarily possess PHI related to payment activities.
3. Health Care Operations. Health Care Operations refers to the basic business functions necessary to operate **SCHOOLCARE**. Examples of uses and disclosures under this section include conducting quality assessment studies to evaluate **SCHOOLCARE**'s overall performance or the performance of a particular network, vendor or other Business Associate; the use of PHI in determining the cost impact of benefit design changes; the disclosure of PHI to underwriters for the purpose of calculating premium rates and insurance quotes to **SCHOOLCARE**; the disclosure of PHI to stop-loss or excess insurance carriers to obtain claim reimbursements to **SCHOOLCARE**; disclosure of PHI to consultants who provide legal, actuarial and auditing services to the plan; and use of PHI in general data analysis used in

the long term management and planning for **SCHOOLCARE** and the Coalition. Again, **SCHOOLCARE** will not generally conduct these types of activities directly, but will instead utilize the services of its Business Associate, Connecticut General. Accordingly, **SCHOOLCARE** will not ordinarily possess PHI related to health care operations.

Other Uses and Disclosures Allowed Without Authorization

Federal law also allows a health plan to use and disclose PHI without your consent or authorization in the following ways:

1. To you, as the covered individual.
2. To a personal representative designated by you to receive your PHI or to a personal representative designated by law, such as the parent or legal guardian of a child, or the duly appointed representative of the estate of a deceased individual.
3. To the Secretary of Health and Human Services (HHS) or any employee of HHS as part of an investigation to determine our compliance with the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rules.
4. To a Business Associate as part of a contracted agreement to perform services for **SCHOOLCARE**.
5. To a health oversight agency, such as the Department of Labor (DOL), the Internal Revenue Service (IRS) and the New Hampshire Insurance Commissioner's Office, to respond to inquiries or investigations of the plan, requests to audit the plan, or to obtain necessary licenses.
6. In response to a court order, subpoena, discovery request or other lawful judicial or administrative proceeding.
7. As required for law enforcement purposes; for example, to notify authorities of a criminal act.
8. In providing you with information about treatment alternatives and health services that may be of interest to you as a result of a specific medical condition.

The examples of permitted uses and disclosures listed above are not provided as an all-inclusive list of the ways in which PHI may be used. They are provided to describe in general the types of uses and disclosures that may be made.

OTHER USES AND DISCLOSURES

Other uses and disclosures of your PHI will only be made upon receiving your written authorization, unless otherwise permitted or required by law as described in this Notice. You may revoke an authorization at any time by providing written notice to the Coalition that you wish to revoke an authorization. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or disclosed your PHI in good faith with the authorization.

YOUR RIGHTS IN RELATION TO PROTECTED HEALTH INFORMATION

Important: As indicated above, SCHOOLCARE will not ordinarily possess PHI. Accordingly, you may wish to contact our Business Associate, Connecticut General, directly with respect to the rights described in the following paragraphs. The CIGNA Healthcare Privacy Officer contact information is set forth at the end of this Notice.

Right to Request Restrictions on Uses and Disclosures

You have the right to request that **SCHOOLCARE** limit its uses and disclosures of PHI in relation to treatment, payment and health care operations or not use or disclose your PHI for these reasons at all. You also have the right to request the plan restrict the use or disclosure of your PHI to family members or personal representatives. Any such request must be made in writing to the Privacy Contact listed at the end of this Notice and must state the specific restriction requested and to whom that restriction would apply. **SCHOOLCARE** is not required to agree to a restriction that you request, and we will notify you in writing whether we will agree to the requested restriction.

Right to Receive Confidential Communications

You have the right to request that communications involving PHI be provided to you at an alternative location or by an alternative means of communication. **SCHOOLCARE** is required to accommodate any reasonable request if the normal method of disclosure would endanger you and that danger is stated in your request. Any such request must be made in writing to the Privacy Contact listed at the end of this Notice.

Right to Access Your Protected Health Information

You have the right to inspect and copy your PHI that is contained in a designated record set for as long as **SCHOOLCARE** maintains the PHI. You also have the right to inspect and copy your PHI that is maintained by **SCHOOLCARE's** Business Associates. A designated record set contains claim information, premium and billing records and any other records **SCHOOLCARE** has created in making claim and coverage decisions relating to you. Federal law does prohibit you from having access to the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding; and PHI that is subject to a law that prohibits access to that information. If your request for access is denied, you may have a right to have that decision reviewed. Requests for access to your PHI should be directed to the Privacy Contact listed at the end of this Notice.

Right to Amend Protected Health Information

You have the right to request that PHI in a designated record set be amended for as long as **SCHOOLCARE** or its Business Associates maintain the PHI. **SCHOOLCARE** may deny your request for amendment if it determines that the PHI was not created by **SCHOOLCARE**, is not part of designated record set, is not information that is available for inspection, or that the PHI is accurate and complete. If your request for amendment is declined, you have the right to have a statement of disagreement included with the PHI and **SCHOOLCARE** has a right to include a rebuttal to your statement, a copy of which will be provided to you. Requests for amendment of your PHI should be directed to the Privacy Contact listed at the end of this Notice.

Right to Receive an Accounting of Disclosures

You have the right to receive an accounting of all disclosures of your PHI that **SCHOOLCARE** and its Business Associates have made, if any, for reasons other than treatment, payment and health care operations, as described above, and disclosures made to you or your personal representative. Your right to an accounting of disclosures applies only to PHI created by **SCHOOLCARE** or its Business Associates after July 1, 2003 and cannot exceed a period of six years prior to the date of your request. Requests for an accounting of disclosures of your PHI should be directed to the Privacy Contact listed at the end of this Notice.

Right to Receive a Paper Copy of this Notice

You have the right to receive a paper copy of this Notice upon request. This right applies even if you have previously agreed to accept this Notice electronically. Requests for a paper copy of this Notice should be directed to the Privacy Contact listed at the end of this Notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with **SCHOOLCARE** or the Secretary of Health and Human Services. Complaints should be filed in writing with the Privacy Contact listed at the end of this Notice. **SCHOOLCARE** will not retaliate against you for filing a complaint.

PRIVACY CONTACT

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT THE SCHOOLCARE/NH SCHOOL HEALTHCARE COALITION PRIVACY OFFICER. THE PRIVACY OFFICER CAN BE REACHED AT THE ADMINISTRATIVE OFFICES OF THE COALITION, LOCATED AT 370 HARVEY ROAD, STE. 4, MANCHESTER, NH 03103, OR YOU MAY CALL 1-800-562-5254.

IMPORTANT: YOU MAY ALSO CONTACT CIGNA HEALTHCARE DIRECTLY WITH ANY QUESTIONS OR REQUESTS. CONNECTICUT GENERAL WILL POSSESS MOST PROTECTED HEALTH INFORMATION AND MAKE IT AVAILABLE TO YOU AS REQUIRED BY THE PRIVACY RULE. YOU MAY WRITE TO: PRIVACY OFFICER, CIGNA HEALTHCARE P.O. BOX 5200, SCRANTON, PA 18505, OR YOU MAY CALL 1-800-762-9940.

EFFECTIVE DATE OF NOTICE. This Notice first became effective on July 1, 2003 and was revised effective July 1, 2008.

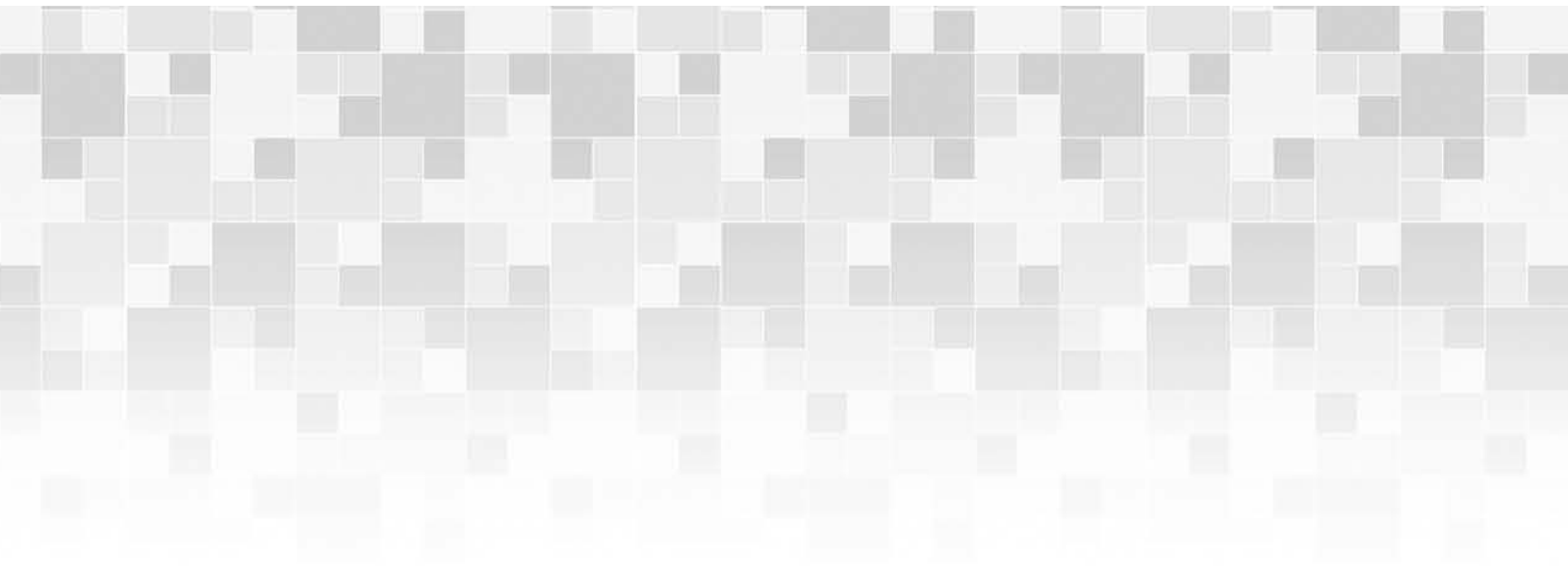
16. MISCELLANEOUS PROVISIONS

- A. **Major Disaster or Epidemic.** In the event of major disaster, epidemic, war or other circumstances beyond the control of CG, CG will make a good faith effort to provide or arrange for Covered Services. However, CG will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.
- B. **Administrative Policies Relating to this Health Benefits Booklet.** The Coalition, CG, and CIGNA HealthCare may adopt reasonable policies, procedures, rules and interpretations that promote orderly administration of the **SCHOOLCARE** benefits program, as described in this Health Benefits booklet.
- C. **Entire Health Benefits Booklet.** This Health Benefits Booklet, along with any endorsements or riders attached hereto, the Schedules of Benefits and Enrollment Application represent the entire agreement between the Subscriber, the Coalition and CG. No employee or agent of the Coalition, CG or any of its Participating Providers, other than written amendment by the Chief Executive Officer of CG and the Coalition, may bind the Coalition and CG to any other terms, payment or coverage.
- D. **Identification Cards.** Identification Cards are for identification only. Possession of a CIGNA HealthCare Identification card does not confer any right to receive Covered Benefits and Services. To be entitled to receive Covered Benefits and Services, the cardholder must be a Member for whom Premium payments have been paid. If a Member permits the use of his/her Identification Card by any other person, CG or the Coalition may reclaim the card and terminate all **SCHOOLCARE** benefits and the rights of such Member and other Members of his/her family as described in this Health Benefits Booklet after providing notice under Section 8. In the case of loss or theft of a membership Identification Card, such occurrence

must be reported immediately to the Coalition and CG. By using the Identification card to obtain Covered Services, the Member agrees to all the terms and conditions on the Enrollment Application and this Health Benefits Booklet, including allowing CG access to medical records for utilization management and quality purposes, and to coordinate benefits.

- E. **Notice to a Subscriber.** Official notices from the Coalition, CG or CIGNA HealthCare will be delivered to the latest name and address listed for the Subscriber and/or Dependents as noted on the Enrollment Application provided to the Coalition. Members are responsible for notifying in writing their employer and the Coalition of any changes in name and address.
- F. **Time Limitation of Actions.** No action at law shall be brought against CG, CIGNA HealthCare, the Coalition or **SCHOOLCARE** for failing to provide Covered Services, unless: (1) it is brought within one year from the date that the original claim was filed; and (2) the Member has availed himself/herself of all rights under the Appeal Procedures, as outlined in Section 13.
- G. **No Implied Waiver.** Failure by **SCHOOLCARE**, the Coalition or CG to enforce any rights conferred by this Health Benefits Booklet shall not be construed as a waiver of any rights in the future.
- H. **Primary Care Physician/Provider Organization.** In some of the benefit plans offered by the Coalition and CG, the Member will be asked to select a Primary Care Physician. The PCP will provide most of the Member's care and will coordinate the Member's care when Referrals or Prior Approval is Medically Necessary. The Member's choice of a PCP may affect the Physicians, Hospitals and other providers to which the Member may be referred.
- I. **Non-Participating Providers.** In certain **SCHOOLCARE** plans, benefits are provided only when the PCP refers to another CIGNA HealthCare Participating Provider. No services are covered when Referrals are made to Non-Participating Providers, unless specifically authorized in writing by CG.
- J. **Change of Primary Care Physician.** A Member may change his/her PCP by contacting CG, either by calling Member Services or at the personalized mycigna.com website. The change must be received by CG by the 25th of the month in order to be effective on the first day of the following month.
- K. **Successors and Assignability.** The provisions of the **SCHOOLCARE** benefits program as described in this Health Benefits Booklet shall be binding upon and shall inure to the benefit of the successors and assigns of the Coalition and CG, but shall not be assignable by any Member.
- L. **Clerical Error.** No clerical error on the part of the Coalition or CG shall operate to defeat any of the rights, privileges or benefits of any Member.
- M. **Section Headings.** Section headings are for convenience only and are not intended to aid in the interpretation of any benefit.
- N. **Cross-References.** Cross-references are provided for convenience of the reader and are not intended as exclusive references to all applicable provisions.
- O. **Severability.** If any term, provision, covenant or condition of this Health Benefits Booklet, (including any endorsements or riders attached hereto) is held by a court of competent jurisdiction to be invalid, void, or unenforceable, all remaining provisions shall continue in full force and effect and shall not otherwise be impaired or invalidated.

NOTES



This booklet describes the benefits, limitations and exclusions for the SCHOOLCARE health benefit plans including HMO, POS Open Access, and Open Access+. It replaces all similar documents previously issued to you by SCHOOLCARE or CIGNA Healthcare. Verify with your employer which SCHOOLCARE plans are available to you before completing an enrollment application.

SCHOOLCARE

NH School Health Care Coalition

370 Harvey Rd, Suite 4

Manchester, NH 03103

800-562-5254 Phone

603-369-4200 Fax (Eligibility and Enrollment)

www.schoolcare.org

7-1-10