Colby College

CIGNA MEDICARE SURROUND

EFFECTIVE DATE: January 1, 2015

CN023
3332414

This document printed in March, 2015 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
THIS IS NOT A STANDARDIZED MEDICARE SUPPLEMENT PLAN
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CIGNA HEALTH AND LIFE INSURANCE COMPANY
a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: The President and Trustees of Colby College

GROUP POLICY(S) — COVERAGE
3332414 - MSUP  CIGNA MEDICARE SURROUND

EFFECTIVE DATE: January 1, 2015

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

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

The Policy is guaranteed renewable for periods of one year, with limited exceptions (specifically, the Policyholder’s failure to pay premium; fraud or intentional misrepresentation of material fact by the Policyholder or by you or your representative; failure of the employee group to have the number of employees purchasing the insurance coverage that Cigna requires in order to provide coverage; or when, if ever, Cigna decides to no longer offer insurance coverage at all or the specific type of insurance provided for in this certificate).

Anna Krishtul, Corporate Secretary

HC-CER1 04-10
V5
Explanation of Terms
You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

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

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

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

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

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

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

CLAIM REMINDERS

• BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA’S CLAIM FORMS, OR WHEN YOU CALL CIGNA CUSTOMER SERVICE.

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

YOUR CIGNA ACCOUNT/GROUP NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR CIGNA IDENTIFICATION CARD. PROVIDE YOUR MEDICARE CLAIM IDENTIFICATION NUMBER AS IT APPEARS ON YOUR MEDICARE ID CARD.

BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

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

Eligibility - Effective Date

Insurance for Eligible Persons

This plan is offered to you as an Eligible Person. To be insured, you may have to pay part of the cost.

You will become eligible for insurance on the day you are in a Class of Eligible Persons.

Classes of Eligible Persons

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

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by completing the application process, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election.

Insurance for Dependents

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

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

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

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by completing the application process, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Eligibility Restrictions

The Eligible Person must enroll for coverage under either this plan or a Related Plan in order to enroll for Dependent Insurance.
Cigna Medicare Surround  
(Part A and Part B)

The Schedule

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

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

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

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

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

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>PART A EXPENSES PLAN PAYS</th>
<th>PART B EXPENSES PLAN PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Applies to Part A and B expenses</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Coinsurance Levels</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part A</td>
<td>Coinsurance as shown below of the amount approved by Medicare but not paid by Medicare</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Part B Deductible</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Remainder of expenses after the Part B Deductible</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>PART A EXPENSES PLAN PAYS</td>
<td>PART B EXPENSES PLAN PAYS</td>
</tr>
<tr>
<td>----------------------------------------</td>
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</tr>
<tr>
<td>Part B Excess Charges</td>
<td>Not Applicable</td>
<td>80% after plan deductible up to the Medicare limiting charge, or the Maximum Reimbursable Charge whichever is less</td>
</tr>
<tr>
<td>Charges above approved Medicare amounts for providers that do not accept the Medicare assignment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Reimbursable Charge</td>
<td>Not Applicable</td>
<td>80th Percentile</td>
</tr>
<tr>
<td>Maximum Reimbursable Charge is determined based on the lesser of the provider’s normal charge for a similar service or supply; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected.</td>
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</tr>
<tr>
<td>Note:</td>
<td></td>
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</tr>
<tr>
<td>The provider may bill you for the difference between the provider’s normal charge and the Maximum Reimbursable Charge, in addition to any applicable deductibles and coinsurance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Applies to Part A and Part B expenses)</td>
<td>$500 per person</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Applies to Part A and Part B expenses)</td>
<td>$1500 per person</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital - Facility Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-private room and board, general nursing and miscellaneous services and supplies. A new benefit period begins each time the member is out of the hospital more than 60 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days 1 - 150 per benefit period (using 60 lifetime reserve days)</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>PART A EXPENSES PLAN PAYS</td>
<td>PART B EXPENSES PLAN PAYS</td>
</tr>
<tr>
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</tr>
<tr>
<td>Once Lifetime Reserve days are used (or would have ended if used) additional 365 days of confinement per person per lifetime Days 1-365</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>Inpatient Services at Other Health Care Facilities</strong>&lt;br&gt;Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities&lt;br&gt;First 20 days&lt;br&gt;21st – 100th day&lt;br&gt;101st – 365th day</td>
<td>Medicare pays in full.&lt;br&gt;80% after plan deductible of the amount approved by Medicare but not paid by Medicare&lt;br&gt;80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
<td>Not Applicable&lt;br&gt;Not Applicable&lt;br&gt;Not Applicable</td>
</tr>
<tr>
<td><strong>Hospice/Inpatient Respite Care</strong>&lt;br&gt;(includes Bereavement Counseling)</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>Physician’s Services</strong></td>
<td><strong>PART A EXPENSES PLAN PAYS</strong>&lt;br&gt;Primary Care Physician’s Office Visit&lt;br&gt;Specialty Care Physician’s Office Visit&lt;br&gt;Surgery Performed In the Physician’s Office&lt;br&gt;Second Opinion Consultations (provided on a voluntary basis)&lt;br&gt;Allergy Treatment/Injections</td>
<td><strong>PART B EXPENSES PLAN PAYS</strong></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>Not Applicable</td>
<td>$20 PCP per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>Not Applicable</td>
<td>$20 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Surgery Performed In the Physician’s Office</td>
<td>Not Applicable</td>
<td>$20 PCP or $20 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Second Opinion Consultations (provided on a voluntary basis)</td>
<td>Not Applicable</td>
<td>$20 PCP or $20 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Allergy Treatment/Injections</td>
<td>Not Applicable</td>
<td>$20 PCP or $20 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>PART A EXPENSES PLAN PAYS</td>
<td>PART B EXPENSES PLAN PAYS</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Preventive Care</td>
<td>Not Applicable</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Annual Routine Physical exam age 18 and over (includes certain screenings). Also covers a one time per lifetime “Welcome to Medicare” exam.</td>
<td>Not Applicable</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Immunizations age 18 and over (includes flu shots, hepatitis B shots and Pneumococcal shots)</td>
<td>Not Applicable</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Early Cancer Detection Screenings</td>
<td>Not Applicable</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Associated Exams</td>
<td>Not Applicable</td>
<td>100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Outpatient Facility Services - Surgical Facility and Free Standing Ambulatory Surgery Center</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Operating Room, Recovery Room, Procedures Room and Treatment Room</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Outpatient Facility Services Non-Surgical Facility</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Including but not limited to radiation therapy, chemotherapy, x-ray, MRI, CT Scan, PET Scan or lab services when done in an outpatient hospital facility</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Inpatient Hospital Physician’s Visits/Consultations</td>
<td>Not Applicable</td>
<td>$20 PCP or $20 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Inpatient Hospital Professional Services</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Surgeon/Assistant Surgeon Radiologist Pathologist Anesthesiologist</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Surgeon/Assistant Surgeon Radiologist Pathologist Anesthesiologist</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>PART A EXPENSES</td>
<td>PART B EXPENSES</td>
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<tr>
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</tr>
<tr>
<td>Emergency and Urgent Care Services</td>
<td></td>
<td>$20 PCP or $20 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Emergency Room Physician</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Urgent Care Facility or Outpatient Facility</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Independent x-ray and/or Lab Facility in conjunction with an ER visit</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Laboratory, Radiology Services and Advanced Radiological Imaging (includes diagnostic tests, pre-admission testing, MRIs, MRAs, CAT Scans and PET Scans)</td>
<td></td>
<td>$20 PCP or $20 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Physician’s Office</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Outpatient Hospital Facility - non-Surgical Facility</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Independent X-ray and/or Lab Facility</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>PART A EXPENSES PLAN PAYS</td>
<td>PART B EXPENSES PLAN PAYS</td>
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<tr>
<td><strong>Outpatient Short-Term</strong></td>
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<tr>
<td><strong>Rehabilitative Therapy and Chiropractic Care Services</strong></td>
<td></td>
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</tr>
<tr>
<td>Maximum: Unlimited up to Medicare limits</td>
<td>Not Applicable</td>
<td>$20 per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Includes:</td>
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<tr>
<td>Physical Therapy</td>
<td></td>
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<tr>
<td>Speech Therapy</td>
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<tr>
<td>Occupational Therapy</td>
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<tr>
<td>Chiropractic Therapy (includes Chiropractors)</td>
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<tr>
<td>Pulmonary Rehab</td>
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<tr>
<td>Cognitive Therapy</td>
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<tr>
<td>Cardiac Rehab</td>
<td></td>
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<tr>
<td><strong>Home Health Care</strong></td>
<td></td>
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<tr>
<td>Maximum: Unlimited</td>
<td>Not covered by plan. Medicare pays in full.</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
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<tr>
<td><strong>Maternity Care Services</strong></td>
<td></td>
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</tr>
<tr>
<td>Initial Visit to Confirm Pregnancy</td>
<td>Not Applicable</td>
<td>$20 PCP or $20 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB/GYNs are considered Specialists</td>
<td></td>
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</tr>
<tr>
<td>All subsequent Prenatal Visits, Postnatal Visits and Physician’s Delivery Charges (i.e. global maternity fee)</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits in addition to the global maternity fee when performed by an OB/GYN or specialist</td>
<td>Not Applicable</td>
<td>$20 PCP or $20 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
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<tr>
<td></td>
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</tr>
<tr>
<td>Delivery - Facility</td>
<td>Same as plan’s Inpatient Hospital Facility benefit</td>
<td>Same as plan’s Outpatient Surgical Facility benefit</td>
</tr>
<tr>
<td>(Inpatient Hospital)</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>(Birthing Center)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th></th>
<th>PART A EXPENSES PLAN PAYS</th>
<th>PART B EXPENSES PLAN PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abortion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes non-elective procedures only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>Not Applicable</td>
<td>$20 PCP or $20 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Same as plan’s Inpatient Hospital Facility benefit</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Not Applicable</td>
<td>Same as plan’s Outpatient Facility benefit</td>
</tr>
<tr>
<td>Inpatient Physician’s Services</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Outpatient Physician’s Services</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
</tbody>
</table>

| **Family Planning Services** |                           |                           |
| Surgical Sterilization Procedure for Vasectomy/Tubal Ligation Limited to Medicare covered services (excludes reversals) |                           |                           |
| Physician’s Office | Not Applicable | $20 PCP or $20 Specialist per office visit deductible then 100% of the amount approved by Medicare but not paid by Medicare |
| Inpatient Facility | Same as plan’s Inpatient Hospital Facility benefit | Not Applicable |
| Outpatient Facility | Not Applicable | Same as plan’s Outpatient Facility benefit |
| Inpatient Physician’s Services | Not Applicable | 80% after plan deductible of the amount approved by Medicare but not paid by Medicare |
| Outpatient Physician’s Services | Not Applicable | 80% after plan deductible of the amount approved by Medicare but not paid by Medicare |
### BENEFIT HIGHLIGHTS

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

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

### Organ Transplants

Includes all medically appropriate, non-experimental transplants

<table>
<thead>
<tr>
<th>Inpatient Facility</th>
<th>Same as plan’s Inpatient Hospital Facility benefit</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Physician’s Services</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Outpatient Physician’s Services</td>
<td>Not Applicable</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Travel Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Durable Medical Equipment

<table>
<thead>
<tr>
<th>Maximum: Unlimited</th>
<th>Not Applicable</th>
<th>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</th>
</tr>
</thead>
</table>

### External Prosthetic Appliances

<table>
<thead>
<tr>
<th>Maximum: Unlimited</th>
<th>Not Applicable</th>
<th>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</th>
</tr>
</thead>
</table>

### Diabetic Supplies and Services

<table>
<thead>
<tr>
<th>Not Applicable</th>
<th>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>PART A EXPENSES PLAN PAYS</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Same as plan’s Inpatient Hospital Facility benefit</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Inpatient Physician’s Services</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Outpatient Physician’s Services</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>Dental Care</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to Medicare covered services</td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Same as plan’s Inpatient Hospital Facility benefit</td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>TMJ Surgical and Non-surgical</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Routine Foot Disorders</strong></td>
<td></td>
</tr>
<tr>
<td>Includes only services associated with foot care for diabetes and peripheral vascular disease.</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>Blood</strong></td>
<td></td>
</tr>
<tr>
<td>First 3 pints in a calendar year</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>Additional amounts per calendar year</td>
<td>80% after plan deductible of the amount approved by Medicare but not paid by Medicare</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>PART A EXPENSES PLAN PAYS</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Part B Covered Prescription Drugs</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Smoking Cessation Counseling</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Same as plan’s Inpatient Hospital Facility benefit</td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
</tr>
<tr>
<td>Individual Therapy</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Foreign Travel</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:</td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum: $Unlimited</td>
<td></td>
</tr>
</tbody>
</table>
Cigna Medicare Surround

Covered Expenses

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

- charges made by a Hospital for Part A Medicare Eligible Expenses for a Hospital Confinement from the first day through the 150th day in any Medicare Benefit Period (includes 60 lifetime reserve days).
- charges made by a Hospital for a Hospital Confinement for an additional 365 days per benefit period per person per lifetime once the lifetime reserve days are used (or would have ended if used).
- charges made by a Skilled Nursing Facility, rehabilitation hospital and sub-acute facilities for Part A Medicare Eligible Expenses from the 21st day through the 100th day in any Medicare Benefit Period. A person must have been in the Hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the Hospital.
- charges made by a Skilled Nursing Facility from the 101st day through 365th day (days in excess of those covered by Medicare). A person must have been in the Hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the Hospital.
- charges made for Hospice/Inpatient Respite Care for Part A Medicare Eligible Expenses which includes bereavement counseling for a terminally ill person.
- charges made for Part A Medicare Eligible Expenses for the first 3 pints of blood in a calendar year or equivalent quantities of packed red blood cells as defined under federal regulations unless replaced in accordance with federal regulations.
- charges made for Part A Medicare Eligible Expenses for additional amounts of blood after the first 3 pints in a calendar year.
- charges made for the Medicare Part B Deductible.
- charges made for the Medicare Approved Amounts remaining for Part B Medicare Eligible Expenses including but not limited to:
  - charges made for Inpatient and Outpatient Physicians services.
  - charges made for laboratory and radiology services.
  - charges for Medicare Eligible Expenses for preventive care for an annual routine physical and a one time “Welcome to Medicare” exam.
  - charges made for immunizations.
  - charges for the following Early Cancer Detection Screenings including but not limited to:
    - pap test and pelvic examination;
    - prostate cancer screening and digital exam;
    - mammogram screening;
    - colonoscopy;
    - sigmoidoscopy;
    - fecal blood test; and
    - barium enema.
  - charges made for Part B Medicare Eligible Expenses for the first 3 pints of blood in a calendar year or equivalent quantities of packed red blood cells as defined under federal regulations unless replaced in accordance with federal regulations.
  - charges made for Part B Medicare Eligible Expenses for additional amounts of blood after the first 3 pints in a calendar year.
  - charges made for outpatient short-term rehabilitative therapy.
  - charges made for home health care services.
  - charges made for maternity.
  - charges made for family planning surgical related services.
  - charges made for durable medical equipment and external prosthetic appliances.
  - charges made for diabetic supplies, including but not limited to: blood glucose test strips, blood glucose monitor, lancet devices and lancets, glucose control solutions for checking accuracy of test strips and monitors and therapeutic shoes or inserts.
  - charges made for clinical trials.
  - charges made in an outpatient facility, emergency room or urgent care facility.
  - charges made for ambulance services.
charges made for routine foot disorders for diabetes and peripheral vascular disease when Medically Necessary.

- charges made for prescription drugs including but not limited to: antigens, osteoporosis drugs, erythropoiesis, blood clotting factors, injectable drugs, immunosuppressive drugs, oral cancer drugs, and oral anti-nausea drugs.

- charges for smoking cessation counseling.

- charges made for mental health and substance abuse.

- charges made for organ transplants.

- charges made for dental care.

- charges made for any Foreign Travel Emergency Services deductible and for the charges remaining after any such deductible. Covered Expenses will include any Emergency Services that begin within the first 60 days of travel outside the United States in a year.

- Part B Excess charges for providers who do not accept Medicare assignment after any Medicare Part B Deductible is met. Coverage will be provided for the difference between the actual Medicare Part B charge as billed and the Medicare approved Part B charge.

In addition, the following exclusions apply to any service that is a Covered Expense under this plan, but is not covered by Medicare:

- care for health conditions that are required by state or local law to be treated in a public facility.

- care required by state or federal law to be supplied by a public school system or school district.

- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.

- treatment of an Injury or Sickness which is due to war, declared, or undeclared.

- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.

- for or in connection with experimental, investigational or unproven services.

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 utilization review Physician to be:

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;

- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section(s) of this plan; or

- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” section(s) of this plan.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.

- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.

- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.

Exclusions

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

- any expense that is:
  - not a Medicare Eligible Expense; or
  - beyond the limits imposed by Medicare for such expense; or
  - excluded by name or specific description by Medicare; except as specifically provided under the “Covered Expenses” section or any other portion of this certificate including any riders attached.

- any portion of a Covered Expense to the extent paid or payable by Medicare;

- any benefits payable under one benefit of this plan to the extent payable under another benefit of this plan;

- Covered Expenses incurred after coverage terminates.
• private Hospital rooms and/or private duty nursing.
• personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
• blood administration for the purpose of general improvement in physical condition.
• for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
• massage therapy.

General Limitations

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

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

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

Subrogation/Right of Reimbursement

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

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

Lien of the Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

• No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan’s right to recover shall apply to decedents’, minors’, and incompetent or disabled persons’ settlements or recoveries.
• In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney’s fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

Calculation of Covered Expenses
Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

• the methodologies in the most recent edition of the Current Procedural terminology.
• the methodologies as reported by generally recognized professionals or publications.

Payment of Benefits
To Whom Payable
Medical Benefits are assignable to the provider if the provider does not participate with Medicare. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient’s payment on the charge, it is the provider’s responsibility to reimburse the patient. All claims for providers that participate with Medicare will be assigned to the provider.

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

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

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

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

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

Termination of Insurance
Eligible Persons
Your insurance will cease on the earliest date below:

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

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

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

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

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

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

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order, provided the child is otherwise eligible under this plan.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

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

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

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

- **Loss of eligibility for State Medicaid or Children’s Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
• **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan’s network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.

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

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

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

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the adoption of a Dependent child, coverage will be effective immediately on the date of adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

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

**Coverage for Maternity Hospital Stay**

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

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

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

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

Claim Determination Procedures under ERISA
The following complies with federal law. Provisions of the laws of your state may supersede.

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

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

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

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

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

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

Concurrent Medical Necessity Determinations
When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent Medical
Notice of Adverse Determination

representative responds to the notice of missing information, and the determination period will resume on the date you or your representative responds to the notice. Cigna will notify you or your representative of the determination within 45 days after receiving the request.

Postservice Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna’s control Cigna will notify you or your representative within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

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

Postservice Claim Determinations

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

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

Notice of Adverse Determination

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation
If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

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

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

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

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

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

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

COBRA Continuation for Retirees Following Employer’s Bankruptcy

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

Interaction With Other Continuation Benefits

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

Clinical Trials

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

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

(b) either

- the referring health care professional is a participating health care provider and has concluded that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

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

The clinical trial must meet the following requirements:

The study or investigation must:

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

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

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

- the investigational drug, device, item, or service, itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

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

ERISA Required Information

The name of the Plan is:

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

Rose Griffin
5500 Mayflower Hill
Waterville, ME 04901
207-859-5503

Employer Identification Number (EIN):
010211497

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

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

The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The Plan’s fiscal year ends on 12/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

**Plan Type**

The plan is a healthcare benefit plan.

**Collective Bargaining Agreements**

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

**Discretionary Authority**

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

**Plan Modification, Amendment and Termination**

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

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

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

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

**Statement of Rights**

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

**Receive Information About Your Plan and Benefits**

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

- receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

**Continue Group Health Plan Coverage**

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

**Prudent Actions by Plan Fiduciaries**

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

**Enforce Your Rights**

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

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

**Assistance with Your Questions**

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

**Definitions**

**Dependent**

Dependents are:

- your lawful spouse who is eligible for Medicare;
- your Domestic Partner who is eligible for Medicare; and
- any unmarried child of yours who is eligible for Medicare by reason of disability who is:
  - 18 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child’s condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

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

Benefits for a Dependent child will continue until the last day of the calendar month in which the Dependent child is no longer eligible for Medicare by reason of disability.

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

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:
- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

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

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

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

Emergency Services
Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily injury or serious sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or 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, provided such symptoms reasonably indicate an emergency.

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

Expense Incurred
An expense is incurred when the service or the supply for which it is incurred is provided.
Hospice Care Services
The term Hospice Care Services means any Medicare Eligible Expenses provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a home health care agency, a hospice facility, or any other licensed facility or agency under a hospice care program.

Hospital
The term Hospital means:
- an institution that is approved by Medicare and has agreed to participate in Medicare.
- An institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance Abuse or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

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

Hospital Confinement or Confined in a Hospital
A person will be considered Confined in a Hospital if he is a registered bed patient in a Hospital upon the recommendation of a Physician.

Injury
The term Injury means an accidental bodily injury.

Maximum Reimbursable Charge - Medical
The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge and help determining the Maximum Reimbursable Charge for a specified service is available upon request by calling the toll-free number shown on your ID card.

Medically Necessary/Medical Necessity
“Medically necessary health care" means health care services or products provided to an enrollee for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:
- consistent with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- demonstrated through scientific evidence to be effective in improving health outcomes;
- representative of "best practices" in the medical profession; and
- not primarily for the convenience of the enrollee or physician or other health care practitioner.

Medicare
The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.
Medicare Approved Amount
The term Medicare Approved Amount means the amount in the Original Medicare Plan that a Physician or supplier can be paid, including what Medicare pays and any deductible, coinsurance or copayment that you pay. It may be less than the actual amount charged by a Physician or supplier.

Medicare Eligible Expenses
The term Medicare Eligible Expenses means expenses covered by Medicare to the extent recognized as reasonable by Medicare.

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

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

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

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

Physician
The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:
- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

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

Related Plan
The term Related Plan means the Policyholder’s employee health plan.
Sickness
The term Sickness means a physical illness. This includes mental illness and substance abuse.

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

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

Certificate Rider
You will become insured on the date you become eligible, if you are in a class of Eligible Persons on that date.
This certificate rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified in the certificate.
The provisions set forth in this certificate rider comply with legislative requirements of Maine. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.
Your certificate is amended to include the following Notices:

Important Notice Regarding Cancellation of Coverage
This notice is to advise you that you have the right to designate a third party to receive notice of cancellation of your coverage under this plan.

Designation of Third Party to Receive Notice
If you would like to designate a third party to receive notice of cancellation of your coverage, you can call Customer Service at 1-800-244-6224 or the phone number shown on your ID card. Customer Service will send to you a “Third Party Notice Request Form,” which you should complete and return to your Employer or Plan Administrator, as appropriate.
You also have the right to change the person or party you have designated to receive notice of cancellation of your coverage. A request to change designation should be made in writing to your Employer or Third Party Administrator.

Right to Reinstatement for Insureds with Organic Brain Disease
Should your coverage be cancelled, you have the right to have your coverage reinstated if:
- you suffer from an organic brain disease; and
- the reason your coverage cancelled was because you did not pay your premium or because of another lapse or default on your part.

“Organic brain disease” means a mental or nervous disorder with a demonstrable organic origin, causing significant cognitive impairment, including, but not limited to:
- Pick’s Disease;
- Parkinson’s Disease;
- Huntington’s Chorea; and
- Alzheimer’s Disease and related dementias.

Important Notice
Benefits provided by this plan are payable in accordance with the following:
- the lifetime maximum per covered person, if any, will not be less than $1,000,000;
- cost sharing for benefits covered under the plan will not exceed 50%;
- the out-of-pocket maximum after any deductible which may be applicable, will not exceed $10,000 per covered person per year; and
- any deductible amount stated on a per person, per family, per illness, per benefit period, per year basis, or combination thereof, will not exceed 5% of the lifetime maximum for each covered person.

The following is added to the medical section of your certificate entitled “Covered Expenses”:
- charges for metabolic formulas and special modified low-protein food products, when prescribed by a Physician, for a person with an inborn error of metabolism for special modified low-protein food products. Low protein food products do not include foods naturally low in protein and are covered to a limit of $3,000 per calendar year.
- charges for annual mammogram screenings for women 40 years of age and older. Mammogram screenings are radiologic procedures provided to an asymptomatic woman for the purpose of early detection of breast cancer and that consists of two radiographic views per breast. A screening mammogram also includes an additional radiolocal procedure recommended by a provider when the results of an initial radiological procedure are not definitive.
- charges for screening Pap tests recommended by a Physician.
charges made for the purchase of a hearing aid for an individual from birth through age 18, for each hearing-impaired ear, in accordance with the following requirements:

- The hearing loss must be documented by a Physician or a licensed audiologist.
- The hearing aid must be purchased from a licensed audiologist or a licensed hearing aid dealer.

Coverage is limited to $1,400 per hearing aid for each hearing-impaired ear every 36 months.

charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for repair or replacement of a prosthetic device if repair or replacement is determined appropriate by your provider.

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

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

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

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

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses;
  - semirigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.

- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

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

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

The following braces are specifically excluded: Copes scoliosis braces.

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

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

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Coverage for replacement is limited as follows:

- no more than once every 24 months for persons 19 years of age and older;
- no more than once every 12 months for persons 18 years of age and under; and
replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices, except for state-required coverage for microprocessors; and
- myoelectric prostheses peripheral nerve stimulators.
- annual gynecological examination, including routine pelvic and clinical breast examinations, performed by a Physician, certified nurse practitioner or certified nurse midwife.
- charges for inpatient coverage with respect to the treatment of breast cancer, for a period of time determined by the attending Physician, in consultation with you, to be medically appropriate following a mastectomy, lumpectomy or lymph node dissection for the treatment of breast cancer.
- charges for a drug prescribed for the treatment of cancer for a medically accepted indication, even if the drug has not been approved by the federal Food and Drug Administration for that indication. However, use of the drug must be a medically accepted indication for the treatment of cancer, in general. "Medically accepted indication" means another use of the drug if that use is supported by one or more citations in the standard reference compendia (the United States Pharmacopeia Drug Information or the American Hospital Formulary Service Drug Information) or the Plan, based on guidance from the federal Medicare program, determines such use is medically accepted based on supportive clinical evidence in peer-reviewed medical literature. Coverage includes Medically Necessary services given in connection with the administration of the drug.
- charges for a drug prescribed for the treatment of HIV or AIDS, even if the drug has not been approved by the federal Food and Drug Administration for that indication, as long as the drug is recognized for the treatment of that indication in one of the standard reference compendia (the United States Pharmacopeia Drug Information or the American Hospital Formulary Service Drug Information) or in peer-reviewed medical literature. Coverage includes Medically Necessary services given in connection with the administration of the drug.
- charges for Medically Necessary breast reduction and/or symptomatic varicose vein surgery.
- charges made for a person who has been diagnosed as having twelve months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;
    - physical, occupational and speech therapy;
    - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

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

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

The following is added to the section of your Certificate entitled “Exclusions”:

- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
The following is added to the section of your Certificate entitled “Payment of Benefits”:

**Time of Payment**

Benefits will be paid by Cigna when it receives due proof of loss.

The following provision is added to your certificate:

**Medical Benefits Extension Upon Policy Cancellation**

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you are or your Dependent is Totally Disabled on that date due to an Injury or Sickness, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group policy; except Cigna will pay benefits as secondary payer in coordination with the succeeding plan;
- the date you are no longer Totally Disabled or no longer Confined in a Hospital;
- 6 months from the date your Medical Benefits cease; or
- 6 months from the date the policy is canceled.

**Totally Disabled**

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

The following is added to your certificate:

**When You Have A Complaint Or An Appeal**

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

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

**Start with Customer Service**

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 20 days.

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

**Appeals Procedure**

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

Cigna
National Appeals Unit (NAU)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

**Level One Appeal**

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

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 20 working days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that your appeal be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete...
an expedited level-one appeal would be detrimental to your medical condition.

Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing within two working days of the oral response.

**Level Two Appeal**

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 20 working days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level-two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing within two working days of the oral response.

**Independent Review Procedure**

You also have the right to appeal an unfavorable decision, including denials based on experimental or pre-existing conditions, by way of the State of Maine's independent review process. Your request must be in writing and sent to the State of Maine, Bureau of Insurance, 34 State House Station, Augusta, ME 04330. A request for an independent review must be submitted within 12 months of the date that you receive an adverse determination (decision) under Cigna's complaint and appeals process. When you request an independent review from the Maine's Bureau of Insurance, you may submit additional information for consideration. You may attend the review in person, by telephone, by teleconference or other appropriate electronic means, ask questions of the representatives and have outside assistance.

The Independent Review Organization will issue a written decision within 30 days of receipt of a completed review from Maine's Bureau of Insurance.

You may call Cigna at the toll-free telephone number on your ID card for assistance in filing a request for an independent review with the Maine's Bureau of Insurance. There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization. The Independent Review Program is a voluntary program arranged by Cigna.

You may also call Maine's Bureau of Insurance at 1-800-300-5000 for assistance.
Appeal to the State of Maine
You have the right to contact the Superintendent of Insurance for assistance at any time. The Superintendent of Insurance may be contacted at the following address and telephone number:

State of Maine
Maine Bureau of Insurance
Superintendent of Insurance
34 State House Station
Augusta, ME 04333
1-800-300-5000

Notice of Benefit Determination on Appeal
Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring a civil action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

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

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