MassMutual Employee Welfare Benefits Plan

High Deductible Health Plan (HDHP)
Option 1 and Option 2
Medical Summary Plan Description
for Employees of MassMutual

Effective January 1, 2011

This Summary Plan Description (SPD), published in March 2011, takes the place of any SPDs and Summaries of Material Modifications (SMMs) previously issued to you describing your benefits.
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Disclaimer

This Summary Plan Description (SPD) provides details of a medical option available through the MassMutual Employee Welfare Benefits Plan (the “Plan”). This SPD contains detailed and important information about the Plan; every attempt has been made to communicate this information clearly and in easily understandable terms. This SPD replaces and supersedes all previous SPD versions and Summaries of Material Modifications (SMMs).

Benefits are determined under the terms of the Plan in effect at the time you become eligible for the specific benefits. Benefits are based on current laws and regulations, which are subject to change. Massachusetts Mutual Life Insurance Company (“the Company” or “MassMutual”) reserves the right to modify, revoke, change, suspend or terminate any one or all plans, programs, policies, benefits or services described in this SPD or the underlying Plan documents at any time and from time to time, with or without notice. This SPD does not guarantee any particular benefit. Receipt of this SPD describing the Plan or option for which you are not eligible does not imply that you are eligible.

This SPD is part of the Plan documents that control this Plan. However, in the event of a discrepancy between descriptions in this SPD and other information in relevant Plan documents, the Plan documents will govern.
Introduction

This Summary Plan Description (SPD) describes the CIGNA High Deductible Health Plan (HDHP) options. You have a choice of medical options. Be sure to read this SPD so you are aware of all Plan provisions.

You will need to satisfy the requirements described in this SPD to receive coverage. Be sure to read through this booklet to learn more about your medical option, including who is eligible, how the Plan works, and what is and is not covered.
Eligibility

Eligible Employees

You are eligible for medical coverage under the Plan if you are an employee regularly scheduled for at least 20 hours per week for one of the following:

- Babson Capital Management LLC
- Centennial Asset Management Corp.
- Cornerstone Real Estate Advisers LLC
- HarbourView Asset Management, Corp.
- Invicta Advisors LLC
- Massachusetts Mutual Life Insurance Company
- MassMutual International LLC
- MML Investors Services, Inc.
- OFI Institutional Asset Management, Inc.
- OFI Private Investments, Inc.
- OFI Trust Company
- Oppenheimer Real Asset Management, Inc.
- OppenheimerFunds Distributor, Inc.
- OppenheimerFunds International, Ltd.
- OppenheimerFunds, Inc.
- Shareholder Financial Services, Inc.
- Shareholder Services, Inc.
- The MassMutual Trust Company, FSB
- Tremont Group Holdings, Inc.
- Trinity Investment Management Corp.

Ineligible Employees

You are not eligible for Plan coverage if you are:

- Not employed by one of the entities listed above;
- Otherwise excluded by specific Plan terms;
- A person who is not recorded as an employee on the employment and payroll records of a participating employer, including anyone who is subsequently reclassified by a court of law or regulatory body as a common law employee of that company;
- A person who performs services for an employer as an independent contractor, under an employee leasing arrangement or any other non-employee or non-payroll classification;
- An intern or school-to-work employee; or
- An employee regularly scheduled to work fewer than 20 hours per week except during a period in which he or she is a trainee in a company training program or temporarily working an increased schedule, such as school breaks and vacations.
Eligible Dependents

You may cover certain Dependents, including:

- Your Spouse (not including an ex-Spouse);
- Your Domestic Partner, as defined below;
- Your Eligible Dependent Child(ren) (see the Eligible Dependent Children section below); and
- For residents of U.S. jurisdictions where same-sex marriage is recognized, your eligible same-sex Spouse and eligible children of your same-sex Spouse. Note:
  - The value of coverage for your Spouse is included as income for federal tax purposes but may be excluded as income for state-tax purposes, if appropriate; and
  - Eligible Dependent Children of a same-sex Spouse generally are treated in the same manner as the Spouse with respect to state and federal taxation of medical benefits.

MassMutual reserves the right to verify a Dependent’s eligibility status for Plan coverage at any time, or from time to time.

Domestic Partner

A Domestic Partner is someone of the same or opposite sex who:

- Has lived together with you as a domestic partner for at least 12 consecutive months before enrollment in the Plan;
- Is at least 18 years old;
- Is not legally married to or separated from anyone else;
- Is not related any closer than would make a marriage illegal;
- Is your sole domestic partner and intends to remain so indefinitely;
- Shares financial responsibilities and expenses with you; and
- Has resided together with you as if married and intends to do so indefinitely.

You must submit:

- A signed Affidavit of Domestic Partnership form and three forms of supporting documentation to apply for coverage for your Domestic Partner;
- Within 30 days of the termination of your partnership, a signed Termination of Domestic Partnership form to remove a Domestic Partner from your coverage if you are ending your partnership. Note: You cannot enroll a new Domestic Partner as a Dependent for at least 12 months following the removal of a previous Domestic Partner or marriage.

The above forms are available online at myHR (or BenefitsChoice for OppenheimerFunds, Inc. Participants).

Eligible Dependent Children

You can cover any of the following children, without further requirement, through the end of the month in which the child turns age 26 if the child is:

- Your son;
- Your daughter;
- Your stepson;
- Your stepdaughter;
- Legally adopted;
• Lawfully placed with you for legal adoption; or
• A foster child placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

**Additional Eligible Dependent Children**

In addition, you may cover:

• A child for whom you are the legal guardian (*Note: Generally, legal guardianship ends at age 18*);
• A child for whom the court has issued a [Qualified Medical Child Support Order (QMCSO)](#); and
• Your [Domestic Partner’s](#) child, if your [Domestic Partner](#) is covered under the Plan.

For any of the additional **Eligible Dependent Children** listed above to be covered, the child must:

• Be covered under your Plan before age 19;
• If older than age 18 (up to age 25), be a student enrolled in an accredited two-or four-year college or university (undergraduate or graduate program) or a post-high school trade or technical school on a full-time basis, as defined by the school’s regulations for full-time students;
• Not be an active member in the armed forces;
• Not be employed on a full-time basis;
• Not be married; and
• Be your IRS tax dependent.

In addition to the above requirements, any additional **Eligible Dependent Child’s** principal residence must be the same as your residence for six or more months of the calendar year. However, full-time student’s principal residence is considered to be his/her parent’s address, even if living on- or off-campus.

**Note:** As of January 1, 2010, Michelle’s Law allows a **Dependent** child older than age 18 who can no longer attend school on a full-time basis because of a [Medically Necessary](#) leave of absence to continue coverage under the Plan for up to one year, or the date coverage would otherwise terminate under Plan terms. A physician’s written certification of the medical leave is required. You will need to complete a *Student Medical Leave Affidavit*. Contact MassMutual Benefits or OFI Human Resources to request this form.

**Important Notes**

• A **Dependent** with a mental or physical disability is eligible for coverage beyond applicable age limits if the child is unmarried and physically or mentally incapable of self-care as determined by the Social Security Administration. If your child becomes disabled while covered under the Plan, your child may be eligible beyond applicable age limits; medical carrier certification and approval is required and certain other provisions apply. For more information, contact MassMutual Benefits or OFI Human Resources.

• If at any time your child is not considered an eligible **Dependent** under this Plan, your child’s coverage will stop at the end of the month in which your child no longer meets the eligibility requirements. You must notify MassMutual Benefits or OFI Human Resources within 30 days of the date on which your child no longer meets the eligibility requirements.

• Your newborn child is eligible for coverage at birth. To enroll, you must notify MassMutual Benefits or OFI Human Resources within 30 days of the child’s birth. If notification is not received within 30 days, the child cannot be added to the Plan until the next **Annual Benefits Enrollment** period or applicable/appropriate **Qualified Change in Status** event.
In the case of adoption, a child becomes eligible for coverage when the child is placed with you for adoption and you have assumed the legal obligation of total or partial support in anticipation of adoption. You must notify MassMutual Benefits or OFI Human Resources within 30 days of adoption or placement for adoption. If notification is not received within 30 days, the child cannot be added to the Plan until the next Annual Benefits Enrollment period or applicable/appropriate Qualified Change in Status event.

If you and your Spouse are both eligible employees, you can cover your Spouse as a Dependent under your Plan (or vice versa) or your Spouse (or you) can elect separate employee coverage. Neither of you can be covered as both employee and Dependent under the Plan.

If you and your Spouse are both eligible employees, only one of you can cover your child as a Dependent under the Plan.

If your Domestic Partner is covered under the Plan, you may cover your Domestic Partner’s children as defined above; however, your Domestic Partner’s children do not need to be dependent upon you financially as defined by the IRS if they are financially dependent on your Domestic Partner.

If you and your Dependent child are both eligible employees, you may cover your child as a Dependent under the Plan provided your child meets the Dependent child eligibility requirements. Or, your child can cover him or herself under the Plan. However, you cannot cover your Dependent child at the same time he or she receives coverage independently under the Plan.

If the Company receives a medical child support order for your Dependent and determines that it is a Qualified Medical Child Support Order (QMCSO), the Dependent will be provided coverage under the Plan. Plan rules for all medical plan options apply. Both you and your covered Dependents must be covered by the same option. You or your Dependents can obtain procedures for QMCSO determinations at no charge from MassMutual Benefits or OFI Human Resources.

If you or a Dependent experience a qualifying event that would entitle you to elect COBRA continuation coverage (see the COBRA section), you or your Dependent(s) must notify MassMutual Benefits or OFI Human Resources within 60 days of the COBRA qualifying event or you may lose your right to elect COBRA. The COBRA TPA will provide you with costs and information about how to continue COBRA coverage when you become eligible.

In accordance with the Genetic Information and Nondiscrimination Act (GINA), the Plan does not use genetic information to determine eligibility, premiums or contributions.
Enrollment

Enrolling in the Plan

You have 30 days from your date of hire to enroll in medical coverage. If you do not elect coverage, you will not be covered under the Plan. However, during the Annual Benefits Enrollment period each fall you will have the opportunity to elect coverage effective the first of the following year.

Certain eligible Participants who did not enroll in coverage during the Annual Benefits Enrollment period in the fall of 2010 and were notified by MassMutual Benefits or OFI Human Resources by February 28, 2011, were eligible to enroll in the Plan on an After-Tax basis for the 2011 Plan Year only.

In addition, if you have a Qualified Change in Status, you may be eligible to elect or change coverage during the Plan Year. You must contact MassMutual Benefits or OFI Human Resources within 30 days of your qualified event to make changes to your coverage. Refer to the Qualified Change in Status section.

When Coverage Begins

Initial Eligibility

You and your eligible Dependents’ medical coverage is effective as of your date of hire. You must enroll within 30 days of this date. You are charged for coverage as of the first day coverage begins. The Plan does not include any pre-existing condition restrictions, which means you will not be denied medical coverage due to your health status.

Annual Benefits Enrollment

You may change your medical coverage once a year during the Annual Benefits Enrollment period (or when you have a Qualified Change in Status; see the Qualified Change in Status section).

During the Annual Benefits Enrollment period, you may:

- Elect coverage, if previously waived;
- Drop coverage;
- Change options; or
- Change your level of coverage (e.g., change from individual plus Spouse to individual coverage).

Any changes you make during Annual Benefits Enrollment are effective on the first day of the next calendar year. If you end coverage for yourself and/or any of your Dependents during the Annual Benefits Enrollment period, your Dependent(s) will not be eligible to continue coverage under COBRA; changes made during Annual Benefits Enrollment are not considered COBRA qualifying events.

Qualified Change in Status

Any change to your medical option due to a Qualified Change in Status must be consistent with and on account of the Qualified Change in Status. If you have a Qualified Change in Status, you can change your existing level of medical coverage (e.g., changing from individual to family coverage) or you may be able to enroll in coverage for the first time if you previously waived coverage. You must make any changes and provide documentation within 30 days of your Qualified Change in Status.
Qualified Changes in Status include:

- A change in the number of your **Dependents**, due to birth, death, adoption, placement for adoption, addition of a foster child or child for whom you have become a legal guardian;
- Your **Dependent** becoming eligible or ineligible;
- A change in your legal marital status, such as marriage, the death of a **Spouse** or divorce;
- Your **Spouse**’s plan having a different coverage period (for example, his or her **Plan Year** runs from July 1 – June 30 rather than MassMutual’s **Plan Year**, which is January 1 – December 31);
- Your **Spouse** or your **Dependent** decreasing or increasing hours of employment, including a move from part-time to full-time or vice versa, which results in a loss or gain of coverage; and
- Your **Spouse** or **Dependent** gaining or losing employment resulting in a loss of coverage.

Changes you make due to a **Qualified Change in Status** become effective as of the date of your **Qualified Change in Status**. However, in the case of a **Dependent** becoming ineligible, your change in benefits is effective the first of the month following the **Dependent**’s loss of eligibility.

To make changes to your medical coverage (e.g., changing from individual to individual plus **Spouse** coverage), you must notify MassMutual Benefits or OFI Human Resources and provide documentation within 30 days of the event. Regardless of any medical coverage option change, mid-year **Deductible** changes are not allowed.

**Special Enrollment Rules**

**Loss of Other Coverage or Gain of a Dependent**

If you do not elect medical coverage for yourself or your eligible **Dependents** (including your **Spouse**) because, for example, you have other medical coverage, you may be eligible to enroll yourself and your **Dependents** in this Plan. If you lose your other coverage, you will be eligible to request enrollment within 30 days of losing the other coverage; you will need to provide documentation with your request. In addition, if you have a new **Dependent** as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your eligible **Dependents**, provided that you request enrollment and provide documentation within 30 days after the marriage, birth, adoption or placement for adoption.

**Medicaid or State Children’s Health Insurance Program (CHIP)**

You and your eligible **Dependents** may enroll in the Plan at a later date if you meet any of the following conditions:

- You or your **Dependent(s)** were covered under a Medicaid Plan or state CHIP and that coverage terminated due to a loss of eligibility; or
- You or your **Dependent(s)** become eligible for assistance from a Medicaid Plan or state CHIP, with respect to coverage under the Plan.

In both cases, you must request special enrollment and provide documentation within 60 days of the loss of Medicaid or CHIP or of the eligibility determination.
Cost of Coverage

You and the Company pay the cost for coverage. Contributions are made to the MassMutual Employee Health Benefits Trust and trust assets are used to fund Plan benefits or pay claims and administrative fees.

Your contributions are generally deducted from your pay on a **Before-Tax** basis. This means that contributions are taken before federal and most state and local taxes, which lowers your taxable income.

Your cost for medical coverage is based on the level of coverage you choose; the coverage levels that you may select are:

- Individual;
- Individual plus **Spouse/Domestic Partner** (if eligible);
- Individual plus child(ren); or
- Family.

The cost of coverage is subject to change at any time.

**Imputed Income**

If you elect medical coverage for your **Domestic Partner** or same sex **Spouse**, you will be responsible for “imputed income.” This means that the fair market value of the coverage for your **Domestic Partner** or same sex **Spouse** (and any coverage for your **Domestic Partner’s** or same sex **Spouse’s** eligible **Dependents**) will be considered income for federal tax purposes (state taxes may also apply in states that do not recognize domestic partners and/or same-sex spouses). If these **Dependents** qualify as your dependents as defined by the IRS, imputed income does not apply.

For same-sex married couples living in U.S. jurisdictions that recognize same-sex marriage, the value of medical coverage for a same-sex **Spouse** and his or her eligible **Dependents** will be included as income for federal tax purposes.

In addition, coverage for certain **Eligible Dependent Children** who are covered through the end of the month in which they turn age 26 (see the **Eligible Dependent Children** section) may be included as income for state tax purposes in some states.
## Contact Information

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<td><a href="http://www.CIGNA.com">www.CIGNA.com</a> <a href="http://www.myCIGNA.com">www.myCIGNA.com</a></td>
<td>800-548-3980</td>
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<tr>
<td>Benefits Concepts, Inc. (COBRA and FSA Administrator and Enrollment Administrator for Participants Enrolled on an After-Tax Basis)</td>
<td><a href="http://www.avantserve.com">www.avantserve.com</a></td>
<td>866-629-6350</td>
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<td>Express Scripts (prescription drug coverage)</td>
<td><a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
<td>866-219-1933</td>
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<tr>
<td>MassMutual Benefits</td>
<td>Web site: <a href="https://mmfgonline.massmutual.com">https://mmfgonline.massmutual.com</a> E-mail: <a href="mailto:BenefitsQuestions@MassMutual.com">BenefitsQuestions@MassMutual.com</a></td>
<td>866-662-6448 or Ext. 46169, on business days, 1 – 5 p.m., ET</td>
</tr>
<tr>
<td>OppenheimerFunds, Inc.</td>
<td>To view BenefitsChoice, go to OPNet, click on HR for Policies, select BenefitsChoice for Procedures &amp; Benefits Web site: [<a href="http://opnet/departments/hr">http://opnet/departments/hr</a> contacts/learningdev/hrportal/Index.html](<a href="http://opnet/departments/hr">http://opnet/departments/hr</a> contacts/learningdev/hrportal/Index.html) E-mail: <a href="mailto:BenefitsChoice@oppenheimerfunds.com">BenefitsChoice@oppenheimerfunds.com</a></td>
<td>303-768-3111</td>
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How the Plan Works

You can choose between two High Deductible Health Plan (HDHP) options. Option 1 and Option 2 cover the same services and differ only in the amount you pay toward your Deductible and Out-of-Pocket Maximum as well as your per pay statement contributions. You and the Plan share in the cost of qualified medical expenses. Here’s how:

- **Preventive Care:** Certain preventive care services are covered at 100%; no annual Deductible or Coinsurance apply. The Plan covers these services in full. You pay $0 for eligible preventive services.

- **Deductible:** For all other Covered Services, including prescription drugs, you pay the full cost until you reach your annual Deductible. Deductibles are expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Coinsurance. Deductibles are in addition to Coinsurance.
  - **Individual Deductible:** If you cover yourself only, once the individual Deductible is met, you do not need to meet any further Deductible for the rest of that year.
  - **Family Deductible:** If you cover any Dependents in addition to yourself, once the family Deductible is met, you and your Dependents do not need to satisfy any further Deductible for the rest of that year; this is a collective Deductible. A collective Deductible is one that must be met before the Plan begins to pay any benefits subject to the Deductible for all family members.
  - For certain prescription medications classified as preventive, the Deductible does not apply and you pay only Coinsurance. What you pay in Coinsurance will apply towards the Out-of-Pocket Maximum.
  - Eligible smoking cessation medications will be covered at 100% (no Deductible, no Coinsurance).

- **Coinsurance:** Once you satisfy your individual or family Deductible, you and the Plan share in the cost of eligible medical and prescription drug expenses through Coinsurance. Both Option 1 and Option 2 allow you to visit any licensed provider in the country; but, you will generally pay less if you use an In-Network Provider (see the Maximum Reimbursable Charge section).

- **Out-of-Pocket Maximum:** To limit your financial risk, the Plan has an annual Out-of-Pocket Maximum. This is the most you could pay each year for qualified medical and prescription drug expenses, including your Deductible and Coinsurance; but excluding your per pay statement contributions and any amount over the Maximum Reimbursable Charge (also known as reasonable and customary or R&C, see below).
  - **Individual Maximum:** If you cover yourself only, once the individual Out-of-Pocket Maximum is met, the Plan pays 100% of most Covered Services for the remainder of the year.
  - **Family Maximum:** If you cover any Dependents in addition to yourself, once the family Out-of-Pocket Maximum is met, the Plan pays 100% of most Covered Services for all covered family members for the remainder of the year.
  - Charges for Covered Services incurred for or in connection with non-compliance penalties or amounts exceeding the Maximum Reimbursable Charge do not apply to the Out-of-Pocket Maximum.

- **Health Savings Account:** To help you save for and pay for qualified medical expenses, including prescription drug expenses, you can open a Health Savings Account (HSA). If you open your HSA through CIGNA and JPMorgan Chase, both you and MassMutual can contribute to this special tax-advantaged account. The HSA is not part of this Plan; for more information about your HSA, contact MassMutual Benefits or OFI Human Resources.

Note: When you elect medical coverage, it automatically includes prescription drug coverage. You pay the full cost of prescription drugs (other than eligible smoking cessation medications and certain preventive medications) until you meet the annual Deductible. There is no separate prescription drug Deductible. Once you meet the Deductible (which includes both medical and prescription drug expenses), you and the Plan share in the cost of prescription drugs. You pay a percentage of the cost of the medication, based on the drug tier and whether it is a 30- or 90-day supply. See the Prescription Drug Addendum for more information.
Preventive Care and Preventive Medications

Options 1 and 2 both offer 100% coverage for eligible preventive care. Using preventive services and following recommended health guidelines can help keep you and your family healthy and detect health problems early so that you may avoid a more complicated (and more costly) medical condition later on.

- Eligible preventive care services include routine physical exams, screenings and immunizations that your doctor determines are appropriate based on your age, gender and family history. It is important to note that doctor’s visits to monitor existing conditions are not considered preventive care; therefore, they are subject to the **Deductible** and **Coinsurance**. For more information about which services are considered preventive care, see the Schedule of Benefits and Preventive Care sections.

- A variety of medications classified as preventive will also be covered before the **Deductible**. You will be responsible for **Coinsurance**, which counts toward your annual **Out-of-Pocket Maximum**. These medications can help control a number of common conditions, including high blood pressure, high cholesterol, diabetes, osteoporosis, asthma and obesity. Prescriptions are generally covered through the Express Scripts, Inc. pharmacy benefit; see the Prescription Drug Addendum to this SPD.

Maximum Reimbursable Charge

For out-of-network charges, the Plan pays benefits based on the **Maximum Reimbursable Charge**, previously referred to as the reasonable and customary allowance or R&C. The **Maximum Reimbursable Charge** is the lesser of:

- The provider’s normal charge for a similar service or supply; or
- The 80th percentile of charges made by providers of the service or supply in the geographic area where it is received (using a database selected by CIGNA).

**Note:** The out-of-network provider may bill you for the difference between the provider’s normal charge and the **Maximum Reimbursable Charge**, in addition to any applicable **Deductible** and/or **Coinsurance**.

Participating Providers

**Participating Providers** include physicians, hospitals and other health care professionals and facilities. Consult www.myCigna.com or call the toll-free number on your ID card for a list of Participating Providers in your area. When you use **Participating Providers**, your out-of-pocket costs may be lower.

Opportunity to Select a Primary Care Physician (PCP)

When you elect Medical Coverage, you may select a **PCP** for yourself and your **Dependents** from www.myCigna.com. If you choose to select a **PCP**, the **PCP** you select for yourself may be different from the **PCP** you select for each of your **Dependents**.

Your **PCP’s** role is to provide or arrange for medical care for you and any of your **Dependents**. However, you and your **Dependents** are allowed direct access to **Participating Providers** for **Covered Services**. Even if you select a **PCP**, there is no requirement to obtain a **Pre-Authorization** of care from your **PCP** for visits to the **Participating Provider** of your choice, including participating specialist physicians, for **Covered Services** that do not otherwise require **Pre-Authorization**. However, **Pre-Authorization** may be required for some services; your **Participating Provider** can help you with this process.

In addition, if at any time a **PCP** stops being a **Participating Provider**, you or your **Dependent** will be notified for the purpose of selecting a new **PCP**, if you choose.
Special Plan Provisions

Case Management

Case management is a service provided through a review organization, which assists individuals with certain treatment needs. The goal of case management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or as an inpatient in a hospital or specialized facility. Should the need for case management arise, a case management professional will work closely with you, your family and the attending physician to determine appropriate treatment options that will best meet the patient’s needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for Medically Necessary resources. Case managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case managers are Registered Nurses (R.N.s) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A case manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, case managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the case manager recommends alternate treatment programs and helps coordinate needed resources, the patient’s attending physician remains responsible for the actual medical care.

Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in case management. If you choose to participate, here is how it works:

- You, your Dependent or an attending physician can request case management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, a claim office or a utilization review program may refer an individual for case management.
- The review organization assesses each case to determine whether case management is appropriate.
- You or your Dependents are contacted by an assigned case manager who explains in detail how the program works.
- Following an initial assessment, the case manager works with you, your family and physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The case manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a hospital bed and other durable medical equipment for the home).
- The case manager also acts as a liaison between CIGNA, you, your family and your physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the case manager continues to manage the case to ensure the treatment program remains appropriate to the patient’s needs.

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

Pre-Authorization

Pre-Authorization means the approval received from the review organization before services are provided.

In general, Participating Providers are required to request Pre-Authorization for the following:

- Hospital Inpatient Services;
- Inpatient Services at any participating other health care facility;
• Residential treatment;
• Outpatient Services;
• Advanced radiological imaging;
• Non-emergency ambulance; and
• Transplant services.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Assistant Surgeon Charges

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20% of the surgeon’s allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon before any reductions due to Coinsurance or Deductible amounts.)

Co-Surgeon Charges

The maximum amount payable will be limited to charges made by co-surgeons that do not exceed 20% of the surgeon’s allowable charge plus 20%. (For purposes of this limitation, allowable charge means the amount payable to the surgeons before any reductions due to Coinsurance or Deductible amounts.)

Integrated Personal Health Team (IPHT)

The CIGNA Integrated Personal Health Team – also referenced as MassMutual Live Healthy, Live Well Health Advocates – provides total health management with easy access to one team of health professionals/advocates including individuals trained as nurses, coaches, dieticians, clinicians, counselors, and more – who will listen, understand a person’s needs and help find solutions.

Individuals can partner with a health advocate one-on-one to understand health assessment results; achieve better work/life balance; find local counselors, doctors or other health professionals; get support for mental health, substance abuse and crises; know what to expect if time in the hospital is required; get advice on options in order to make an informed decision with their health professional; and understand the importance of preventive screenings. Telephonic coaching, online self-service tools and print materials support this fully integrated approach to improving and maintaining health. Contact the IPHT 9 a.m. – 9 p.m., Monday – Friday, and 9 a.m. – 1 p.m., Saturday.

CIGNA’S Toll-Free Care Line

CIGNA’s toll-free care line allows you to talk to a health care professional during normal business hours, Monday through Friday, simply by calling the toll-free number shown on your ID card.

CIGNA’s toll-free care line personnel can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may consult the Participating Provider list online at www.myCigna.com, which lists the Participating Providers in your area, or call CIGNA’s toll-free number for assistance. If you or your Dependents need medical care while away from home, you may have access to a national network of Participating Providers through CIGNA’s Away-From-Home Care feature. Call CIGNA’s toll-free care line for the names of Participating Providers in other Network Areas. Whether you obtain the name of a Participating Provider online or through the care line, it is recommended that before making an appointment you call the provider to confirm that he or she is a current Participating Provider in the Plan.
Schedule of Benefits

Notes:
• The option you are covered under is based on the option you elected when you enrolled for coverage. OppenheimerFunds, Inc. Participants are not eligible for Option 2.
• You are covered under the out-of-area option if you do not live in CIGNA’s network Service Area.
• See the Dictionary Terms for more information on the terms used to describe Plan benefits.
• Refer to the Prescription Drug Addendum for information about prescription drug coverage.

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Option 1 In-Network</th>
<th>Out-of-Network</th>
<th>Out-of-Area</th>
<th>Option 2 In-Network</th>
<th>Out-of-Network</th>
<th>Out-of-Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Pre-Existing Condition Limitation</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>After Deductible, Plan pays 90%</td>
<td>After Deductible, Plan pays 70% of R&amp;C</td>
<td>After Deductible, Plan pays 80%</td>
<td>After Deductible, Plan pays 90%</td>
<td>After Deductible, Plan pays 70% of R&amp;C</td>
<td>After Deductible, Plan pays 80%</td>
</tr>
<tr>
<td>Deductible (Plan Year)</td>
<td>Individual: $1,300</td>
<td>$2,600</td>
<td>$1,300</td>
<td>Individual: $2,500</td>
<td>$5,000</td>
<td>$2,500</td>
</tr>
<tr>
<td></td>
<td>Family: $2,600</td>
<td>$2,600</td>
<td>$2,600</td>
<td>Family: $5,000</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (Plan Year)</td>
<td>Individual: $3,000</td>
<td>$5,000</td>
<td>$3,000</td>
<td>Individual: $4,500</td>
<td>$9,000</td>
<td>$4,500</td>
</tr>
<tr>
<td></td>
<td>Family: $5,000</td>
<td>$5,000</td>
<td>$5,000</td>
<td>Family: $9,000</td>
<td>$9,000</td>
<td>$9,000</td>
</tr>
</tbody>
</table>

• All covered expenses, which include prescription drug expenses, count toward the Deductible.
• The individual Deductible applies if only the Participant is enrolled; the family Deductible applies if two or more individuals are enrolled. All family members contribute toward the family Deductible. A single family member or combination of family members can meet the full family Deductible amount.
• Once the applicable individual or family Deductible is met, the Plan begins to Coinsurance; unless indicated otherwise.

• Covered expenses, which include prescription drug expenses, count toward both the in-network and out-of-network Out-of-Pocket Maximums.
• Deductibles count towards the Out-of-Pocket Maximum.
• Non-compliance penalties or charges in excess of the Maximum Reimbursable Charge do not apply to the Out-of-Pocket Maximum.
• The individual Out-of-Pocket Maximum applies if only the Participant is enrolled; the family Out-of-Pocket Maximum applies if two or more individuals are enrolled. All family members contribute toward the family Out-of-Pocket Maximum. A single family member or combination of family members can meet the family Out-of-Pocket Maximum.
• Once the applicable individual or family Out-of-Pocket Maximum is met, the Plan pays 100% of covered expenses for the remainder of the Plan Year.

<table>
<thead>
<tr>
<th>Physician Services</th>
<th>Option 1 In-Network</th>
<th>Out-of-Network</th>
<th>Out-of-Area</th>
<th>Option 2 In-Network</th>
<th>Out-of-Network</th>
<th>Out-of-Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% after Deductible</td>
<td>Plan pays 80% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
<tr>
<td>Plan Feature</td>
<td>Option 1</td>
<td>-option 2</td>
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<tr>
<td></td>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
<td><strong>Out-of-Area</strong></td>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
<td><strong>Out-of-Area</strong></td>
</tr>
<tr>
<td><strong>Primary Care Physician</strong> and specialist office visits</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
<tr>
<td><strong>Allergy treatment/injections</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Allergy serum (dispensed by the physician’s office)</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Surgery performed in the physician’s office</strong></td>
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</tr>
<tr>
<td><strong>Growth hormones</strong> (Medically Necessary) administered in a physician’s office</td>
<td></td>
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</tr>
<tr>
<td><strong>Hospital visits and consultations</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Inpatient Services</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Preventive Care</strong></td>
<td>Plan pays 100%, no Deductible</td>
<td>Plan pays 100%, no Deductible</td>
<td>Plan pays 100%, no Deductible</td>
<td>Plan pays 100%, no Deductible</td>
<td>Plan pays 100%, no Deductible</td>
<td>Plan pays 100%, no Deductible</td>
</tr>
<tr>
<td><strong>Preventive Screenings</strong></td>
<td>Plan pays 100%, no Deductible</td>
<td>Plan pays 100%, no Deductible</td>
<td>Plan pays 100%, no Deductible</td>
<td>Plan pays 100%, no Deductible</td>
<td>Plan pays 100%, no Deductible</td>
<td>Plan pays 100%, no Deductible</td>
</tr>
<tr>
<td><strong>Inpatient Hospital/Facility</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Physician Services</strong></td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
<tr>
<td><strong>Professional Services</strong></td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Surgery Facility Charges</strong></td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
<tr>
<td><strong>Outpatient Professional Services</strong></td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
</tbody>
</table>

**MassMutual HDHP-Employee**

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<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network¹</td>
</tr>
<tr>
<td>Outpatient Short-Term</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
</tr>
<tr>
<td>Rehabilitation Therapies</td>
<td>No limit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Services include: Physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation, cognitive therapy, cardiac rehabilitation</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
</tr>
<tr>
<td>Calendar-Year Limit: 30 visits/days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab and X-Ray</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
</tr>
<tr>
<td>Lab, X-Ray, Pre-Admission Testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services may be performed in a physician’s office, outpatient hospital facility, independent X-ray and/or lab facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab and X-Ray When Part of an Emergency Room/Urgent Care Visit</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
</tr>
<tr>
<td>• When billed by the facility as part of the ER/UC visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Independent X-ray and/or lab facility as part of an emergency room visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Radiological Imaging</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
</tr>
<tr>
<td>Services include: MRI, MRA, CAT scan, PET scan when provided in a physician’s office, inpatient facility or outpatient facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Radiological Imaging When Part of Emergency Room/Urgent Care Visit</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
</tr>
<tr>
<td>Emergency and Urgent Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
</tr>
<tr>
<td>Services include: Radiology, pathology and physician charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
</tr>
<tr>
<td>Out-of-network services are covered at the in-network rate only if it is a true emergency. If not a true emergency, the out-of-network rate (70% of R&amp;C) applies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
</tr>
<tr>
<td>Other Health Care Facilities</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
</tr>
<tr>
<td>Skilled Nursing, Rehabilitation Hospital, and Other Facilities</td>
<td>No days limit</td>
<td></td>
</tr>
</tbody>
</table>
### Plan Feature

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Out-of-Network</th>
<th>Out-of-Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>Out-of-Area</td>
</tr>
<tr>
<td>Home Health Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No days limit</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
</tr>
</tbody>
</table>

- Includes outpatient private duty nursing when approved as **Medically Necessary**
- The maximum number of hours per day is limited to 16. Multiple visits can occur in one day, with a visit defined as a period of 2 hours or less (e.g., maximum of 8 visits per day).

### Option 2

<table>
<thead>
<tr>
<th>Out-of-Network</th>
<th>Out-of-Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice (Inpatient and Outpatient Services)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
</tbody>
</table>

### Other Health Care Services

<table>
<thead>
<tr>
<th>Durable Medical Equipment</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No limit</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
</tr>
</tbody>
</table>

### TMJ – Surgical

<table>
<thead>
<tr>
<th>TMJ – Surgical</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
</tbody>
</table>

### In-Network

| Plan pays 90% after Deductible | Plan pays 70% of R&C after Deductible | Plan pays 80% after Deductible |

- Provided on a limited case-by-case basis; subject to **Medical Necessity**
- Appliances and orthodontic treatment always excluded.

### Infertility

<table>
<thead>
<tr>
<th>Lifetime Maximum: $7,500</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
</tbody>
</table>

- Coverage includes office visit for testing, treatment and artificial insemination, inpatient hospital facility, outpatient hospital facility, physician services, surgical treatment (including both correction and in-vitro fertilization, GIFT, ZIFT, etc.)
- Lifetime maximum is combined per **Member**. Includes all related services billed with an infertility diagnosis (e.g., lab or x-ray services billed by an independent lab/x-ray facility)
- Prescription drugs are covered by Express Scripts and are limited to a separate $7,500 lifetime maximum; see the **Prescription Drug Addendum**

### Family Planning

| Plan pays 90% after Deductible | Plan pays 70% of R&C after Deductible | Plan pays 80% after Deductible |

- Office visits, tests and counseling
- Surgical services, such as tubal ligation or vasectomy are covered (excluding reversals)
- Contraceptive devices and diaphragms when services are provided in the physician’s office

### Behavioral Health

<table>
<thead>
<tr>
<th>Inpatient Mental Health</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No days limit</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Mental Health</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No visit limit</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Substance Abuse</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No days limit</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
</tr>
<tr>
<td>Plan Feature</td>
<td>Option 1</td>
<td>Option 2</td>
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<tr>
<td>---------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Outpatient Substance Abuse</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
</tr>
<tr>
<td>No visit limit</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
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<tr>
<td></td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
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<tr>
<td></td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
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<tr>
<td></td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
</tbody>
</table>

- Partial hospitalization and residential treatment is covered as inpatient mental health and/or substance abuse
- Outpatient mental health includes individual, group and intensive outpatient treatment
- Outpatient substance abuse includes individual and intensive outpatient treatment
- Utilization review and case management is required for Inpatient Services (unless an individual is Medicare primary)

### Additional Benefits

<table>
<thead>
<tr>
<th>Bereavement Counseling</th>
<th>Provided as part of Hospice Care Program; paid the same as inpatient or outpatient hospice depending on where services are provided.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Care Services</td>
<td>Plan pays 90% after Deductible Plan pays 70% of R&amp;C after Deductible Plan pays 80% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 90% after Deductible Plan pays 70% of R&amp;C after Deductible Plan pays 80% after Deductible</td>
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<tr>
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<td>Plan pays 90% after Deductible Plan pays 70% of R&amp;C after Deductible Plan pays 80% after Deductible</td>
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<tr>
<td></td>
<td>Plan pays 90% after Deductible Plan pays 70% of R&amp;C after Deductible Plan pays 80% after Deductible</td>
</tr>
</tbody>
</table>

- Services include:
  - Initial visit to confirm pregnancy
  - All subsequent prenatal visits, postnatal visits and physician’s delivery charges (i.e., global maternity fee)
  - Office visits in addition to the global maternity fee when performed by an OB or specialist
  - Delivery facility charges (e.g., inpatient hospital, birthing center)

- Abortion (elective and non-elective)
- Services include inpatient facility and physician services.
- Travel benefits are only available if you use a LifeSource facility.

<table>
<thead>
<tr>
<th>Organ Transplant</th>
<th>Travel Maximum: $10,000 per transplant, per lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan pays 100% after Deductible at LifeSource center; otherwise Plan pays 90% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 100% after Deductible at LifeSource center; otherwise Plan pays 80% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 100% after Deductible at LifeSource center; otherwise Plan pays 90% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 100% after Deductible at LifeSource center; otherwise Plan pays 80% after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acupuncture</th>
<th>Calendar-Year Maximum: 6 visits combined</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan pays 90% after Deductible Plan pays 70% of R&amp;C after Deductible Plan pays 80% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 90% after Deductible Plan pays 70% of R&amp;C after Deductible Plan pays 80% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 90% after Deductible Plan pays 70% of R&amp;C after Deductible Plan pays 80% after Deductible</td>
</tr>
</tbody>
</table>

**Medically Necessary** services for:
- Nausea and vomiting associated with pregnancy
- Nausea and vomiting associated with chemotherapy
- Post-operative dental pain when due to injury to sound natural teeth
- Postoperative dental pain, if treatment of the dental condition was covered under the Plan
- The following painful conditions: Headache, low back pain, neck pain and knee pain
<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietary Supplement and Nutritional Formulas</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
</tr>
<tr>
<td>Plan-Year Maximum: $2,500 for low protein food-products only</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 80% after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 80% after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 80% after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
<tr>
<td>Covered when required for the treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism) or enteral feeding for which the nutritional formulae under state or federal law can be dispensed only through a physician’s prescription and are <strong>Medically Necessary</strong> as the primary source of nutrition.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Care</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
</tr>
<tr>
<td>Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
</tr>
<tr>
<td>Dental Extraction of Impacted Teeth</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
</tr>
<tr>
<td>Physician’s Office</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Inpatient Hospital Facility</td>
<td>Plan pays 90% after Deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Plan pays 90% after Deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Physician Services</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% after Deductible</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70% after Deductible</td>
</tr>
<tr>
<td>Calendar-Year Maximum: $1,000</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
<td>Plan pays 70% of R&amp;C after Deductible</td>
</tr>
<tr>
<td>Lifetime Maximum: $10,000</td>
<td>Plan pays 80% after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
<tr>
<td>Vision Care²</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 90% after Deductible</td>
</tr>
<tr>
<td>Wigs (Medically Necessary)</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>No limit</td>
<td>Plan pays 90% of R&amp;C after Deductible</td>
<td>Plan pays 90% of R&amp;C after Deductible</td>
</tr>
<tr>
<td>Routine Foot Disorders</td>
<td>Plan pays 80% after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
<tr>
<td>Plan-Year Maximum: $2,500</td>
<td>Plan pays 80% after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
<tr>
<td>Lifetime Maximum: $5,000</td>
<td>Plan pays 80% after Deductible</td>
<td>Plan pays 80% after Deductible</td>
</tr>
<tr>
<td>Includes charges made for diagnosis and treatment of: corns, calluses, weak or flat feet, any fallen arches, chronic foot strain or instability or imbalance of the feet, toenails (other than removal of nail matrix or root, or services furnished in connection with treatment of metabolic or peripheral vascular disease or of a neurological condition). <strong>Note: Medically Necessary</strong> foot orthotics are covered under external prosthetic appliances.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Prescription drug benefits are provided by Express Scripts (1-866-219-1933, Group # K4U); see the Prescription Drug Addendum for more information.</td>
<td>Prescription drug benefits are provided by Express Scripts (1-866-219-1933, Group # K4U); see the Prescription Drug Addendum for more information.</td>
</tr>
</tbody>
</table>
1 Out-of-network charges are subject to the **Maximum Reimbursable Charge**, also known as the reasonable and customary (R&C) charge – this is the normal charge made by a provider for a similar service or supply that does not exceed the charge by most providers in a given geographic region. You are responsible for paying any charges over R&C. Charges above R&C will not apply towards your **Deductible** or **Out-of-Pocket Maximum**.

2 Routine vision care is not covered; for routine care coverage, see the Vision SPD. Vision care for the treatment of a medical condition is covered. Call CIGNA for details.
Covered Services are expenses you incur for the charges listed below if they are incurred after you become covered for these benefits. Expenses incurred for these charges are considered Covered Services 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 illness or injury, as determined by CIGNA. Any amounts you are responsible for paying and any Maximum Reimbursable Charge amounts or limits are shown in the Schedule of Benefits.

Preventive Care

Your doctor determines the tests that are right for you based on your age, gender and family history. The following table shows some services commonly provided as preventive care. This does not guarantee coverage for all preventive services and these services are subject to change.

<table>
<thead>
<tr>
<th>Wellness Exams and Immunizations</th>
<th>Birth to 2 Years</th>
<th>Ages 3 to 10</th>
<th>Ages 11 to 21</th>
<th>Ages 22 and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-Baby/Well-Child/Well-Person Exams (includes height, weight, head circumference, BMI, history, anticipatory guidance, education regarding risk reduction, psychosocial/behavioral assessment)</td>
<td>Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 &amp; 30 months Additional visit at 2-4 days for infants discharged less than 48 hours after delivery</td>
<td>Well child exams; once a year</td>
<td>Once a year</td>
<td>Periodic visits, depending on age</td>
</tr>
<tr>
<td>Diphtheria, Tetanus Toxoids and Acellular Pertussis (DTaP)</td>
<td>2, 4 &amp; 6 months and 15-18 months</td>
<td>Ages 4-6</td>
<td>Tetanus, diphtheria, acellular pertussis (Tdap) given once, ages 11-64</td>
<td>Tetanus and diphtheria toxoids booster (Td) every 10 years; Tdap given once, ages 11-64</td>
</tr>
<tr>
<td>Haemophilus Influenzae Type b Conjugate (Hib)</td>
<td>2, 4 &amp; 6 months and 12-15 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A (HepA)</td>
<td>12-23 months</td>
<td>Ages 3-10 if not previously immunized</td>
<td>Ages 11-18 if not previously immunized</td>
<td>May be required for persons at risk</td>
</tr>
<tr>
<td>Hepatitis B (HepB)</td>
<td>At birth, 1-4 months and 6-18 months</td>
<td>Ages 9-10, as doctor advises</td>
<td>Ages 11-12, catch-up, ages 13-26</td>
<td>Catch-up, through age 26</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV)</td>
<td></td>
<td>Annually 6 months through 18 years</td>
<td>Ages 19-49, as doctor advises</td>
<td>Ages 19-49, as doctor advises Ages 50 and older, annually</td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps and Rubella (MMR)</td>
<td>Ages 12-15 months</td>
<td>Ages 4-6 or 11 &amp; 12 if not given earlier</td>
<td>If not already immune</td>
<td>Rubella for women of childbearing age if not immune</td>
</tr>
<tr>
<td>Meningococcal (MCV)</td>
<td></td>
<td></td>
<td></td>
<td>All persons ages 11-18</td>
</tr>
<tr>
<td>Pneumococcal (Pneumonia)</td>
<td>2, 4 &amp; 6 months and 12-15 months</td>
<td></td>
<td></td>
<td>Ages 65 &amp; older, once (or younger than 65 for those with risk factors)</td>
</tr>
<tr>
<td>Poliovirus (IPV)</td>
<td>2 &amp; 4 months and 6-18 months</td>
<td>Ages 4-6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus</td>
<td>Ages 6-24 weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>Ages 12-18 months</td>
<td>Ages 4-6</td>
<td>Second dose catch-up or if no evidence of prior immunization or chickenpox</td>
<td>Second dose catch-up or if no evidence of prior immunization or chickenpox</td>
</tr>
<tr>
<td>Zoster</td>
<td></td>
<td></td>
<td></td>
<td>Ages 60+</td>
</tr>
<tr>
<td>Health Screenings and Interventions</td>
<td>Birth to 2 Years</td>
<td>Ages 3 to 10</td>
<td>Ages 11 to 21</td>
<td>Ages 22 and Older</td>
</tr>
<tr>
<td>-----------------------------------</td>
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</tr>
<tr>
<td>Alcohol Misuse</td>
<td></td>
<td></td>
<td>All adults</td>
<td></td>
</tr>
<tr>
<td>Aspirin to Prevent Cardiovascular Disease</td>
<td></td>
<td></td>
<td>Men ages 45-79</td>
<td>Women ages 55-79</td>
</tr>
<tr>
<td>Autism</td>
<td>18, 24 months</td>
<td>At each visit</td>
<td>Once a year</td>
<td>Every 2 years or as doctor advises</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol/Lipid Disorders</td>
<td>Screening of children and adolescents (after age 2, but by age 10) at risk due to known family history; when family history is unknown; or with personal risk factors (obesity, high blood pressure, diabetes)</td>
<td>Ages 20 and older if risk factors</td>
<td>All men ages 35 and older, or ages 20-35 if risk factors</td>
<td>All women ages 45 and older, or ages 20-35 if risk factors</td>
</tr>
<tr>
<td>Colon Cancer Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital Hypothyroidism Screening</td>
<td>Newborns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression Screening</td>
<td></td>
<td>Ages 12-18</td>
<td>All adults</td>
<td></td>
</tr>
<tr>
<td>Developmental Screening</td>
<td>7, 18 months</td>
<td>30 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental Surveillance</td>
<td>Newborn 1, 2, 4, 6, 12, 15, 24 months</td>
<td>At each visit</td>
<td>At each visit</td>
<td>Age 45 and older or at any age if asymptomatic with sustained BP greater than 135/80, every 3 years</td>
</tr>
<tr>
<td>Diabetes Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Caries Prevention</td>
<td>Children older than 6 months</td>
<td>Children older than 6 months</td>
<td>Children older than 6 months</td>
<td>Children older than 6 months</td>
</tr>
<tr>
<td>Service</td>
<td>Birth to 2 Years</td>
<td>Ages 3 to 10</td>
<td>Ages 11 to 21</td>
<td>Ages 22 and Older</td>
</tr>
<tr>
<td>---------------------------------------------</td>
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<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Oral Health Evaluation/Assess for Dental Referral</td>
<td>12, 18, 24 months</td>
<td>30 months, 3 years, 6 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Screening <em>(not complete hearing examination)</em></td>
<td>All newborns by 1 month</td>
<td>4, 5, 6, 8 &amp; 10 or as doctor advises</td>
<td>12, 15 &amp; 18 or as doctor advises</td>
<td>65 &amp; older or as doctor advises</td>
</tr>
<tr>
<td>Healthy Diet/Nutrition Counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemoglobin or Hematocrit</td>
<td>12 months</td>
<td></td>
<td>Once a year for females after menarche</td>
<td></td>
</tr>
<tr>
<td>HIV Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iron Supplementation</td>
<td>6-12 months for children at risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Screening</td>
<td>12, 24 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metabolic/Hemoglobinopathies <em>(according to state law)</em></td>
<td>Newborns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity Screening</td>
<td>Ages 6 and older</td>
<td>Ages 6 and older</td>
<td>All adults</td>
<td></td>
</tr>
<tr>
<td>PKU Screening</td>
<td>Newborns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prophylactic Ocular (Eye) Medication to Prevent Blindness</td>
<td>Newborns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate Cancer Screening (PSA)</td>
<td></td>
<td></td>
<td></td>
<td>Once a year for men ages 50 and older or any age with risk factors</td>
</tr>
<tr>
<td>Sexually Transmitted Infections (STI)</td>
<td></td>
<td></td>
<td>All sexually active adolescents</td>
<td>All adults at risk</td>
</tr>
<tr>
<td>Sickle Cell Disease Screening</td>
<td>Newborns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco Use/Cessation Interventions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculin Test</td>
<td>Children at risk</td>
<td>Children at risk</td>
<td>Adolescents at risk</td>
<td></td>
</tr>
<tr>
<td>Ultrasound AAA Screening</td>
<td></td>
<td></td>
<td></td>
<td>Men ages 65-75 who have ever smoked</td>
</tr>
<tr>
<td>Vision Screening <em>(not complete eye examination)</em></td>
<td>3, 4, 5, 6, 8 &amp; 10 or as doctor advises</td>
<td>12, 15 &amp; 18 or as doctor advises</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Women’s Health Screenings and Interventions**

<table>
<thead>
<tr>
<th>Service</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia Screening</td>
<td>Pregnant women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bacteriuria Screening</td>
<td>Pregnant women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion/Referral for Counseling Related to BRCA1/BRCA2 test</td>
<td>Women at risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion About Potential Benefits/Risk of Breast Cancer Preventive Medication</td>
<td>Women at risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening (Mammogram)</td>
<td>Women ages 40 and older, annually</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding Promotion</td>
<td>During pregnancy and after birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Screening (Pap test)</td>
<td>Within 3 years of sexual activity; or ages 21-64, at least every 3 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia Screening</td>
<td>Sexually active women ages 24 and under &amp; older women at risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Folic Acid Supplementation</td>
<td>Women planning or capable of pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhea Screening</td>
<td>Sexually active women at risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Screening</td>
<td>Pregnant women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis Screening</td>
<td>Age 65 or older (or 60 for women at risk)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rh Incompatibility Test</td>
<td>Pregnant women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis Screening</td>
<td>Pregnant women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco Use/Cessation Interventions</td>
<td>Pregnant women</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Covered Services

- Charges made by a hospital, on its own behalf, for bed and board and other necessary services and supplies; except that for any day of hospital confinement, Covered Services will not include that portion of charges for bed and board that is more than the Plan’s bed and board limit.
- Charges for licensed ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided.
- Charges made by a hospital, on its own behalf, for medical care and treatment received as an outpatient.
- Charges made by a free-standing surgical facility, on its own behalf for medical care and treatment.
- Charges made on its own behalf, by another health care facility, including a skilled nursing facility, a rehabilitation hospital or a subacute facility for medical care and treatment.
- Charges made for emergency services and Urgent Care.
- Charges made by a nurse, other than a Member of your family or your Dependent’s family, for professional nursing service.
- Charges made for anesthetics and their administration, diagnostic X-ray and laboratory examinations, X-ray, radium and radioactive isotope treatment, chemotherapy, blood transfusions, oxygen and other gases and their administration.
- Charges made for a mammogram for women ages 35 to 69, every one to two years or at any age for women at risk, when recommended by a physician.
- Charges made for an annual Papanicolaou laboratory screening test.
- Charges made for an annual prostate-specific antigen test (PSA).
- Charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- Charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- Charges made for family planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, and implanted/injected contraceptives.
- Charges made for routine preventive care from age 3, including immunizations. Routine preventive care means health care assessments, wellness visits and any related services.
- Charges made for visits for routine preventive care of a Dependent child during the first two years of that Dependent child’s life, including immunizations.
- Charges made for medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered for an established medical condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Penile implants are not covered as treatment of psychogenic erectile dysfunction.
- Surgical treatment of TMJ dysfunction.
- Charges made for acupuncture; limited to six visits per calendar year as noted in the Schedule of Benefits.
- Hearing aids, including, but not limited to, semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound. Hearing aid benefits are limited to $1,000 per calendar year up to $10,000 per lifetime.
• Charges for dietary supplements and nutritional formulas when required for:
  o The treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism); or
  o Enteral feeding for which the nutritional formulae under state or federal law can be dispensed only through a physician’s prescription and are **Medically Necessary** as the primary source of nutrition.
  o Low protein food products are limited to $2,500 per **Plan Year**.

• Non-prescription enteral formulas where approved and ordered by a **Participating Provider**, **Pre-Authorized** and **Medically Necessary** for the treatment of malabsorption caused by Crohn’s disease or ulcerative colitis, gastroesophageal reflux, gastrointestinal motility or chronic intestinal pseudo-obstruction and inherited disease of amino acids and organic acids, not related to mechanical issues such as the inability to swallow are covered. Benefits also include special medical formulas that are approved by the Massachusetts Commissioner at the Department of Public Health ordered by a **Participating Provider** and are **Medically Necessary** for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup disease, propionic acidemia or methylmalonic acidemia in infants and children or **Medically Necessary** to protect the unborn fetuses or pregnant women with phenylketonuria. Includes coverage of all infant nutritional formula as prescribed by a physician, including, but not limited to, Enfamil powder, polyose, nutramigen and peptamen.

• Inherited diseases of amino acids and organic acids are covered, including food products modified to be low protein. Charges for low-protein modified food products for treatment of inherited metabolic disorders are subject to an annual **Benefit Maximum**.

• Charges for **Medically Necessary** growth hormones.

• Charges for **Medically Necessary** biofeedback.

• Charges for **Medically Necessary** wigs.

• Charges for **Medically Necessary** rhinoplasty and blepharoplasty.

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

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

**Clinical Trials**

• Charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:
  o The cancer clinical trial is listed on the National Institute for Health (NIH) website [www.clinicaltrials.gov](http://www.clinicaltrials.gov) as being sponsored by the federal government;
  o The trial investigates a treatment for terminal cancer and:
    - The person has failed standard therapies for the disease;
    - The person cannot tolerate standard therapies for the disease; or
    - No effective non-experimental treatment for the disease exists;
  o The person meets all inclusion criteria for the clinical trial and is not treated “off-protocol;” and
  o The trial is approved by the Institutional Review Board of the institution administering the treatment.

• Coverage will not be extended to clinical trials conducted at non-participating facilities if a person is eligible to participate in a covered clinical trial from a **Participating Provider**.
• Routine patient services do not include and reimbursement will not be provided for:
  o The investigational service or supply itself;
  o Services or supplies listed herein as exclusions;
  o Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
  o Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial Participant.

Genetic Testing

• Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
  o A person has symptoms or signs of a genetically-linked inheritable disease;
  o It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
  o The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

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

• Genetic counseling is covered if a person is undergoing approved genetic testing or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to three visits per Plan Year for both pre- and post-genetic testing.

Nutritional Evaluation

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

Internal Prosthetic/Medical Appliances

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

Home Health Care Services

• Charges made for home health care services when you:
  o Require skilled care;
  o Are unable to obtain the required care as an ambulatory outpatient; and
  o Do not require confinement in a hospital or other health care facility.

• Home health care services are provided under the terms of a home health care plan for the person named in that plan and then only if CIGNA has determined that the home is a medically appropriate setting.

• If you are a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), home health care services will only be provided for you during times when there is not a family member or care giver present in the home to meet your non-skilled care and/or Custodial Care needs.
Home health care services are those skilled health care services that can be provided during visits by other health care professionals. The services of a home health aide are covered when provided in direct support of skilled health care services provided by other health care professionals. A visit is defined as a period of two hours or less. Home health services are subject to a maximum of 16 hours per day. Necessary consumable medical supplies and home infusion therapy administered or used by other health care professionals in providing home health care services are covered. Home health care services do not include 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 even if that person is another health care professional. Skilled nursing services or private duty nursing services provided in the home are subject to the home health services benefit terms, conditions and benefit limitations. Physical, occupational and other short-term rehabilitative therapy services provided in the home are not subject to the home health services benefit limitations, but are subject to the benefit limitations described under “Short-Term Rehabilitative Therapy.”

Hospice Care Services

- Charges made for a person who has been diagnosed as having six 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 bed and board and services and supplies, except that, for any day of confinement in a private room, Covered Services will not include that portion of charges that is more than the Plan’s hospice bed and board daily limit;
  - 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 another health care facility for:
    - Part-time or intermittent nursing care by or under the supervision of a nurse;
    - Part-time or intermittent services of another 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 Plan if the person had remained or been confined in a hospital or hospice facility.

- The following hospice care services are not included as Covered Services:
  - Charges 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;
  - Charges for services for any period when you or your Dependents are not under the care of a physician;
  - Services or supplies not listed in the hospice care program;
  - Charges for any curative or life-prolonging procedures;
  - Charges for any services to the extent that they are payable under any other part of this Plan (in which case they will be covered under that part of the Plan);
  - Charges for services or supplies that are primarily to aid you or your Dependent in daily living.

Durable Medical Equipment

- Charges made for the purchase or rental of durable medical equipment that is ordered or prescribed by a physician and provided by a vendor approved by CIGNA for use outside a hospital or other health care facility. Coverage for the repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs resulting from a person’s misuse are the person’s responsibility. Coverage is limited to the lowest-cost alternative as determined by the utilization review physician.
• Durable medical equipment is defined as items that are designed for and able to withstand repeated use by more than one person, customarily serve a medical purpose, generally are not useful in the absence of illness or injury, are appropriate for use in the home and are not disposable. Such equipment includes, but is not limited to: crutches, hospital beds, wheelchairs, respirators and dialysis machines.

• Durable medical equipment that is not covered includes, but is not limited to:
  o Bed related items, including bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses including non-power mattresses), custom mattresses and posturepedic mattresses.
  o Bath related items, including bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats and spas.
  o Chairs, lifts and standing devices, including computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer) and auto tilt chairs.
  o Fixtures to real property, including ceiling lifts and wheelchair ramps.
  o Car/van modifications.
  o Air quality items, including room humidifiers, vaporizers, air purifiers and electrostatic machines.
  o Blood/injection related items, including blood pressure cuffs, centrifuges, nova pens and needleless injectors.
  o Other equipment, including heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

External Prosthetic Devices

• Charges made for the initial purchase and fitting of external prosthetic devises that are used as replacements or substitutes for missing body parts and are necessary to alleviate or correct illness, injury or congenital defect; including only artificial arms and legs and terminal devices such as hands or hooks. Replacement of such prostheses is covered only if needed due to normal anatomical growth.

Infertility Services

• Charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed; limited to $7,500 per Member per lifetime for covered medical expenses and $7,500 per Member per lifetime for covered prescription drug expenses, which are covered under the pharmacy program administered by Express Scripts; see the Prescription Drug Addendum for more information. Services include, but are not limited to: infertility drugs that are administered or provided by a physician, approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in-vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and the services of an embryologist.

• Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

• However, the following are specifically excluded infertility services:
  o Infertility medications not administered or provided by a physician;
  o Reversal of male and female voluntary sterilization;
  o Infertility services when the infertility is caused by or related to voluntary sterilization;
  o Donor charges and services;
  o Cryopreservation of donor sperm and eggs; and
  o Any experimental, investigational or unproven infertility procedures or therapies.
**Short-Term Rehabilitative Therapy**

- Short-term rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative and pulmonary rehabilitation therapy when provided in the most medically appropriate setting.
- Relating to short-term rehabilitative therapy, occupational therapy is provided only for enabling persons to perform the activities of daily living after an illness, injury or sickness.
- Short-term rehabilitative therapy services that are not covered include, but are not limited to:
  - Sensory integration therapy, group therapy, treatment of dyslexia, behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
  - Treatment for functional articulation disorder, such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury;
  - Maintenance or preventive treatment consisting of routine, long-term or non-[Medically Necessary care](#) provided to prevent recurrence or to maintain the patient’s current status; and
  - Services provided by a chiropractic physician, which include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

**Chiropractic Care Services**

- Charges made for diagnostic and treatment services utilized in an office setting by chiropractic physicians.
- Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment provided to specific joints to restore motion, reduce pain and improve function. For these services you have direct access to qualified chiropractic physicians.
- Relating to chiropractic care services, occupational therapy is provided only for enabling persons to perform the activities of daily living after an injury or sickness.
- Chiropractic care services that are not covered include, but are not limited to:
  - Services of a chiropractor that are not within his scope of practice, as defined by state law;
  - Charges for care not provided in an office setting;
  - Maintenance or preventive treatment consisting of routine, long-term or non-[Medically Necessary care](#) provided to prevent recurrence or to maintain the patient’s current status; and
  - Vitamin therapy.

**Transplant Services**

- Charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations:
  - Transplant services include the recipient’s medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel, liver or multiple viscera.
  - Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs will consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken before procurement is covered if [Medically Necessary](#). Costs related to the search for and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.
Transplant Travel Services

- Charges made for reasonable travel expenses incurred by you in connection with a Pre-Authorized organ/tissue transplant are covered subject to the following conditions and limitations, up to $10,000 per transplant, per lifetime. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a Pre-Authorized organ/tissue transplant from a designated CIGNA LifeSource Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant-related services during any evaluation, candidacy, transplant event or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at or traveling to and from the transplant site; and food while at or traveling to and from the transplant site.

- In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your Spouse, a member of your family, your legal guardian or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses: travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach-class rates. These benefits are only available when you or your Dependents are the recipient of an organ transplant. No benefits are available when you or your Dependents are a donor.

Breast Reconstruction and Breast Prostheses

- Charges made for reconstructive surgery following a mastectomy, if the patient chooses in the manner chosen by the patient and physician. Services and benefits include:
  - Surgical services for reconstruction of the breast on which surgery was performed;
  - Surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
  - Postoperative breast prostheses; and
  - Mastectomy bras and external prosthetics limited to the lowest-cost alternative available that meets external prosthetic replacement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy are covered.

Reconstructive Surgery

- Charges made for reconstructive surgery or therapy to repair or correct severe disfigurement or deformity that is accompanied by functional deficit (other than abnormalities of the jaw or conditions related to TMJ disorder) if:
  - The surgery or therapy restores or improves function;
  - Reconstruction is required due to Medically Necessary, non-cosmetic surgery; or
  - The surgery or therapy is performed before age 19 and is required due to a congenital absence or agenesis (lack of formation or development) of a body part.

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

Behavioral Health Services

Behavioral health services include coverage for:

- Mental health services, which are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes; and

- Substance abuse services, which are services that are required to treat psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment.
Covered Services include:

- **Inpatient Mental Health Services:** Inpatient mental health services are services that are provided by a hospital while you or your Dependents are confined in a hospital for the treatment and evaluation of mental health, including Medically Necessary mental health residential treatment services. Mental health residential treatment services are services provided by a hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute mental health conditions.

- **Outpatient Mental Health Services:** Outpatient mental health services are services of providers who are qualified to treat mental health when treatment is provided on an outpatient basis, while you or your Dependents are not confined in a hospital, and is provided in an individual, group or mental health intensive outpatient therapy program. Covered Services include, but are not limited to, outpatient treatment of conditions such as anxiety or depression that interfere with daily functioning, emotional adjustment or concerns related to chronic conditions, such as psychosis or depression, emotional reactions associated with marital problems or divorce, child/adolescent problems of conduct or poor impulse control, affective disorders, suicidal or homicidal threats or acts, eating disorders, acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment. Outpatient Services include Intensive Outpatient Program (IOP) treatment.

- **Inpatient Substance Abuse Rehabilitation Services:** Inpatient substance abuse rehabilitation services are services provided for rehabilitation, while you or your Dependents are confined in a hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient substance abuse rehabilitation services include partial hospitalization sessions and residential treatment services.

- **Substance Abuse Residential Treatment Services:** Substance abuse residential treatment services are services provided by a hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute substance abuse conditions.

- **Outpatient Substance Abuse Rehabilitation Services:** Outpatient substance abuse rehabilitation services are services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependents are not confined in a hospital, including outpatient rehabilitation in an individual or substance abuse intensive outpatient therapy program.

- **Substance Abuse Detoxification Services:** Substance abuse detoxification services and related medical ancillary services are provided when Medically Necessary and required for the diagnosis and treatment of addiction to alcohol and/or drugs.

*Note:* Like any other inpatient treatment, inpatient behavioral health services are subject to the Plan’s utilization review provisions.

**Treatment Resulting from Life Threatening Emergencies**

Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a behavioral health expense will be determined by the utilization review physician in accordance with the applicable mixed services claim guidelines.

**Behavioral Health Exclusions**

The following are specifically excluded from behavioral health services:

- Any court-ordered treatment or therapy or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this Plan.

- Treatment of disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain, such as dementia or Alzheimer’s (this does not apply to other dysfunctions such as bipolar disorder or schizophrenia).
• Developmental disorders, including, but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
• Counseling for activities of an educational nature.
• Counseling for borderline intellectual functioning.
• Counseling for occupational problems.
• Counseling related to consciousness raising.
• Vocational or religious counseling.
• I.Q. testing.
• **Custodial Care**, including, but not limited to, geriatric day care.
• Psychological testing on children requested by or for a school system.
• Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.
Exclusions and Limitations

Payment for the following is specifically excluded from this Plan:

- 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 illness or injury that is due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Plan.
- Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other Custodial Care or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined to be:
  - Not demonstrated, through existing peer-reviewed, evidence-based scientific literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed;
  - 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 this Summary Plan Description; or
  - The subject of an ongoing phase I, II or III clinical trial, except as provided in this Summary Plan Description.
- 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.
- The following services are excluded from coverage regardless of clinical indications: Acupressure, dance therapy, movement therapy, applied kinesiology, rolfing and Extracorporeal Shock Wave Lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch. Charges made for extraction of impacted teeth when performed in an inpatient or outpatient hospital are covered under medical plan (primary) and coordinated with any dental (secondary) coverage.
- For medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by a Body Mass Index (BMI) classification of the National Heart, Lung and Blood Institute guideline, is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
- Unless otherwise covered as a basic benefit, 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 being sought by a Participating Provider or otherwise covered in the Summary Plan Description.
• Reversal of male and female voluntary sterilization procedures.
• Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
• Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Plan.
• Non-medical counseling or ancillary services, including, but not limited to, Custodial Care, education, training, vocational rehabilitation, behavioral training, neurofeedback, hypnosis, sleep therapy, employment counseling, back-to-school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
• Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to, routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
• Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the Summary Plan Description.
• Private hospital rooms.
• Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
• Artificial aids, including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
• Aids or devices that assist with non-verbal communications, including, but not limited to, communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
• Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
• Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
• All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in the Summary Plan Description.
• Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
• Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
• Dental implants for any condition.
• Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in CIGNA’s medical director’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
• Blood administration for the purpose of general improvement in physical condition.
• Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
• Cosmetics, dietary supplements (unless otherwise noted) and health and beauty aids.
• Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
• Telephone, e-mail, Internet consultations or other services that under normal circumstances are expected to be provided through face-to-face clinical encounters, unless provided via an approved Internet-based intermediary.
• Massage therapy.
• Non-surgical TMJ.
Claiming Benefits

Filing Claims

When you or your Dependents seek care from a Participating Provider, you are only responsible for your applicable Coinsurance or Deductible amount after CIGNA has been billed and you have received a final bill. You do not need to file a claim form. If your provider requests payment upfront or if you or your Dependents seek care from a non-Participating Provider, you must submit a claim form to be reimbursed.

All fully completed claim forms and bills should be sent directly to your servicing CIGNA Claim Office within one year from the date of service. To obtain the appropriate claim form, contact CIGNA at 800-548-3980.

The prompt filing of any required claim will result in faster payment of your claim. If Medicare is your Primary Plan, claims should be submitted to Medicare first.

Claim Forms

You may get the required claim form by calling CIGNA at 800-548-3980. All fully completed claim forms and bills should be sent to the address listed on your CIGNA ID card.

Be sure to use your Member ID and account number when you file CIGNA’s claim forms or when you call your CIGNA claim office. Your Member ID is the ID number shown on your benefit ID card.

Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

Hospital Confinement

If necessary, get your claim form before you are admitted to the hospital. This form will make your admission easier and any cash deposit usually required will be waived.

Be sure to show your Member ID card to the admission office at the time of your admission. The card tells the hospital where to send bills.

Physician’s Bills and Other Medical Expenses

The first medical claim should be filed as soon as you have incurred Covered Services. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.
Benefit 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 pre-service, concurrent or post-service basis, as described below:

- Certain services require **Pre-Authorization** to be covered. This **Pre-Authorization** is called a “pre-service Medical Necessity determination.” You or your authorized representative (typically, your health care provider) must request **Medical Necessity** determinations according to the procedures described below 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.

**Pre-Service Medical Necessity Determinations**

When you or your representative request a required **Medical Necessity** determination before care, you or your representative will be notified of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond CIGNA’s control, you or your representative will be notified 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 within 45 days after receiving the notice. The determination period will be suspended on the date the notice of missing information is sent, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function or in the opinion of a physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, the pre-service determination will be made on an expedited basis. CIGNA’s physician reviewer, in consultation with the treating physician, will decide if an expedited appeal is necessary. You or your representative will be notified of an expedited determination within 24 hours after receiving the request.

However, if necessary information is missing from the request, you or your representative will be notified within 24 hours after receiving the request of what information is needed. You or your representative must provide the specified information within 48 hours after receiving the notice. You or your representative will be notified 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 three days by written or electronic notification.

If you or your representative do not follow the procedures for requesting a required pre-service **Medical Necessity** determination, you or your representative will be notified of the failure and the proper procedures for filing will be provided within five 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 want to extend the approval, you or your representative must request a required concurrent **Medical Necessity** determination at least 24 hours before the expiration of the approved period or number of treatments. When you or your representative requests such a determination, you or your representative will be notified of the determination within 24 hours after receiving the request.
Post-Service Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, you or your representative will be notified 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, you or your representative will be notified 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 within 45 days after receiving the notice. The determination period will be suspended on the date the notice of missing information is sent, and the determination period will resume on the date you or your representative responds to the notice.

Post-Service Claim Determinations

When you or your representative requests payment for services that have been rendered, you will be notified 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, you or your representative will be notified 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 within 45 days after receiving the notice. The determination period will be suspended on the date the notice of missing information is sent, and resume on the date you or your representative responds to the notice.

If a Claim Is Denied or Reduced

If your claim for benefits is denied or reduced, you will be notified in writing of the reason for the denial. The notice will include:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other relevant information;
- A description of the Plan’s review procedures and the time limits applicable;
- Upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and
- In the case of a claim involving Urgent Care, a description of the expedited review process applicable to that claim.
Appeals Procedures

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.

“Physician reviewers” are licensed physicians depending on the care, service or treatment under review.

Start with Member Services

CIGNA Member Service personnel are available to listen and help. If you have a concern regarding a person, service or the quality of care, you may call the toll-free number on your CIGNA ID card, explanation of benefits or claim form and explain your concern to one of the Member Services representatives. You may also express that concern in writing. CIGNA will do its best to resolve the matter on your initial contact. If more time is needed to review or investigate your concern, CIGNA will respond as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a decision, you may start the appeals process.

Appeals Procedure

CIGNA has a two-step appeals process for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CIGNA within 180 days of receipt of a denial notice. 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 CIGNA to register your appeal by telephone. Call or write CIGNA at the toll-free number on your CIGNA ID card, explanation of benefits or claim form.

You have 180 days from the date the claim was denied to file an appeal.

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.

Your appeal should be sent to:
CIGNA Healthcare
National Appeals Unit
Scranton, PA 18505-5225

For level one appeal, CIGNA will respond in writing with a decision within 15 calendar days after receipt of an appeal for a required pre-service or concurrent care coverage determination or within 30 calendar days after receipt of an appeal for a post-service coverage determination. If more time or information is needed to make the determination, you will be notified in writing of the request for an extension of up to 15 calendar days; the notice will specify any additional information needed to complete the review.

You may request that the appeals process be expedited if:
• The time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your physician would cause you severe pain that cannot be managed without the requested services; or
• Your appeal involves non-Pre-Authorization of an admission or continuing inpatient hospital stay.
CIGNA’s physician reviewer, in consultation with the treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

**Level Two Appeal**

If you are dissatisfied with your level one appeal decision, you may request a second review within 180 days of your receipt of CIGNA’s level one appeal decision. To initiate a level two appeal, follow the same process required for a level one appeal.

Your appeal should be sent to:
CIGNA Healthcare
National Appeals Unit
Scranton, PA 18505-5225

For required pre-service and concurrent care coverage determinations, the Appeal Committee review will be completed within 15 calendar days and for post-service claims, the Appeal Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, you will be notified in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Appeal Committee to complete the review. You will be notified in writing of the Committee’s decision within five business days after the Appeal Committee meeting and within the Appeal Committee review time frames above if the Appeal Committee does not approve the requested coverage. The Appeal Committee refers to the organization doing the second level non-Urgent Care review.

For submitting an Urgent Care appeal at this level, follow the process in level one appeal. You may request that the appeals process be expedited if:
- The time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your physician, would cause you severe pain that cannot be managed without the requested services; or
- Your appeal involves non-Pre-Authorization of an admission or continuing inpatient hospital stay.

The Claim Administrator’s physician reviewer, in consultation with the treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

**Independent Review Procedure**

If you are not fully satisfied with the decision of CIGNA’s level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an independent review organization. The independent review organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect your rights to any other benefits under the Plan.

There is no charge for you to initiate this independent review process. CIGNA will abide by the decision of the independent review organization.

To request a referral to an independent review organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CIGNA. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.
To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CIGNA’s level two appeal review denial. CIGNA will then forward the file to the independent review organization. The independent review organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your medical condition, as determined by CIGNA’s physician reviewer, the review will be completed within three days. The independent review program is a voluntary program arranged by CIGNA.

If an Appeal Is Denied

If your appeal is denied, you will be notified in writing of the reason for the denial. The notice will include:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that you are 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 of your rights to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on a level two appeal;
- Upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and
- In the case of a claim involving Urgent Care, a description of the expedited review process applicable to that claim.

Relevant Information

Relevant information is any document, record or other information that:

- 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 for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

This Plan is governed by ERISA. You have the right to bring a civil action under ERISA Section 502(a) if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against the Plan until you have completed the appeals processes. If your appeal is expedited, there is no need to complete the process before bringing legal action.
About Your Coverage

If You Leave the Company

Your coverage ends on the last day of the pay period in which you stop working for MassMutual, OppenheimerFunds, Inc. or an eligible subsidiary. At that time, you may be eligible for COBRA continuation coverage; refer to the COBRA section for more information.

If You Are Not Working

Taking a leave of absence may affect your coverage. The impact depends on the type of leave you take. If your absence is paid, coverage continues as if you were working. If your absence is unpaid, the cost for your coverage while on leave will be deducted when you return from your leave. Note: If you are receiving benefits under the MassMutual or Oppenheimer Long-Term Disability (LTD) Plan, you may elect to continue medical coverage under a retiree medical option. The following information is a brief summary of two types of leaves; detailed information on leaves, including military leave, is available on MyHR (OPNet for OppenheimerFunds, Inc. Participants).

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) allows eligible individuals to take up to 12 weeks of unpaid leave during any 12-month period due to:

• The birth, adoption or placement with the individual for adoption of a child;
• The care of a seriously ill Spouse parent, or child;
• The individual’s serious illness; or
• A qualifying urgent need for leave because a Spouse, child or parent is on active duty in the armed services in support of a military operation.

In addition, up to 26 weeks of unpaid leave may be available during any 12-month period to care for a service member under certain circumstances.

Your eligibility for FMLA leave and benefits is determined by the Company.

Uniformed Services Employment and Reemployment Rights Act – Military Service

The Uniformed Services Employment and Reemployment Rights Act (USERRA) allows eligible individuals to elect to continue coverage if absent due to service in the uniformed services. Under federal law, the period of coverage available under USERRA will run concurrently with the COBRA continuation coverage period available to you and/or your eligible Dependents. After your discharge from service, you may be eligible to apply for reemployment with the Company in accordance with USERRA. This reemployment includes your right to elect reinstatement in any existing health care coverage provided.

If You Retire

Upon retirement, you may be eligible to continue medical coverage under a MassMutual retiree medical option; contact MassMutual Benefits or OFI Human Resources for more information.
If You Die

If you die while you are an active employee covered by the Plan and if at the time of death:

- You have less than five years of service, your covered **Dependents** may be eligible for COBRA continuation coverage. Refer to the COBRA section for more information. COBRA provides coverage for up to 36 months from the date of your death; or
- If you have five or more years of service, additional provisions may apply.

For more information, contact MassMutual Benefits or OFI Human Resources.

If the Company Ends the Benefit

At this time, the Company expects to continue sponsoring the Plan. However, the Company reserves the right to terminate, modify, amend or suspend the benefit plans, in whole or part, at any time and from time to time without advance notice. This may result in modification or termination of benefits to **Participants**. You will be notified, in writing, of any change or if the benefit ends.

When Coverage Ends

Your medical coverage ends on the first of the following dates:

- The date the Company terminates or amends the Plan eliminating coverage;
- The date the Plan is discontinued;
- The date you are no longer eligible to participate in the Plan;
- The date you retire;
- The date your payment for coverage is not made when due;
- The last day of the pay period in which you stop working for the Company or an eligible subsidiary;
- The date you or your **Dependents** submit a fraudulent claim; or
- Your death.

Your **Spouse/Domestic Partner**’s coverage ends on the first of the following dates:

- The date your coverage ends;
- The date your **Spouse/Domestic Partner** is no longer eligible to participate in the Plan; or
- The date your **Spouse/Domestic Partner** dies.

In addition, your **Spouse/Domestic Partner**’s coverage will end on the first of the following dates. You must notify MassMutual Benefits or OFI Human Resources in writing within 30 days any of the following occurs:

- The date your domestic partnership ends;
- The date your marriage is annulled or you become divorced, whichever is first; or
- The date you or your **Spouse/Domestic Partner** is called to active duty in the armed forces.

Your **Dependent** child’s coverage ends on the first of the following dates:

- The date your coverage ends;
- The date your child is no longer eligible to participate in the Plan; or
- The date your **Dependent** child dies.
In addition, your **Dependent** child’s coverage will end at the end of the month in which your child turns age 26. However, your child’s coverage may end earlier if your child is eligible for coverage as an “additional Eligible Dependent Child,” as described in the Eligible Dependent Children section. For these children, coverage may end on the first of the following dates:

- The date the child is married or employed on a full-time basis;
- The date your disabled child older than age 18 is no longer incapable of self-care;
- For **Domestic Partner** children, the date your domestic partnership ends; or
- The date the child becomes a member in the armed services.

You must notify MassMutual Benefits or OFI Human Resources in writing within 30 days of any of the above events that would cause your child to lose coverage.

When coverage, including COBRA continuation coverage, ends, you and/or your **Dependent** will be provided with a certificate of creditable coverage, free of charge, that indicates the period you and/or your **Dependents** were covered under the Plan, including any additional information, as required by law. When coverage ends, the certificate will be sent within a reasonable time after coverage ends.

This certificate may help reduce or eliminate any pre-existing condition limitation under a new group health care plan. You or your **Dependent** may ask for a certificate at anytime while covered under the Plan or within 24 months of the date your coverage ends.
The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, allows you and your Dependents to temporarily continue coverage (including any Retiree Health Reimbursement Arrangement (RHRA), if eligible) if coverage would end due to certain instances, specified below as qualifying events. Continuation must be elected in accordance with the rules of the Plan and is subject to federal law, regulations and interpretations.

Continuation of Coverage

You and your Dependents may continue your current coverage if it ends because your employment ends for any reason (except gross misconduct) or the number of hours you are scheduled to work are reduced below those required for you to be eligible for benefits.

COBRA coverage also is available to your Dependents if their coverage would otherwise end because of one of the following:

- Your death;
- Your divorce or annulment of your marriage (you must send MassMutual Benefits or OFI Human Resources a copy of your divorce decree or other form of documentation proving you are divorced or your marriage is annulled within 60 days of the date of your divorce or annulment);
- Your child becoming ineligible for coverage (you must notify MassMutual Benefits or OFI Human Resources within 60 days of the date your child becomes ineligible); or
- Your Domestic Partner and your Domestic Partner’s child(ren) become ineligible for coverage (COBRA-like coverage may be available).

COBRA coverage continues for up to 18, 29 or 36 months, depending on how you or your Dependents become eligible as noted in the following chart. If you elect to continue coverage under COBRA, you are required to pay 102% of the cost of coverage in After-Tax dollars (100% plus a 2% administrative fee).

If you are disabled as determined by the Social Security Administration, you may be eligible to continue COBRA for up to 29 months but pay 102% of the cost for coverage for the first 18 months, and then 150% for the remaining 11 months.

If you elect COBRA coverage and the Social Security Administration determines that you or your Dependents were permanently and totally disabled at any time within the first 60 days of the date of continuation coverage, you may be eligible to continue COBRA for up to 29 months but pay 102% of the cost of coverage in After-Tax dollars (100% plus a 2% administrative fee).
Following is a table illustrating the length of COBRA coverage and its relation to the reason why Plan coverage ended:

<table>
<thead>
<tr>
<th>Length of COBRA Coverage (up to)</th>
<th>Reason Coverage Stops (qualifying event)</th>
</tr>
</thead>
</table>
| 18 Months                        | • Your employment terminates or your regularly scheduled hours fall below hours required for benefits eligibility  
• You retire  
• The Company declares bankruptcy |
| 29 Months (18 months plus 11 months, see below) | • You are disabled as determined by the Social Security Administration within the first 60 days of continuation coverage |
| 36 Months (for Dependents)       | • You die  
• You divorce or have your marriage annulled  
• Your child(ren) becomes ineligible |

Note: COBRA-like coverage is available for up to 24 months if you are on a military leave. Information on military leave is available from myHR or OPNet.

**Electing COBRA**

A third party administers COBRA. The COBRA third-party administrator (TPA) will provide you with information about how to continue COBRA coverage at the time you or your Dependents become eligible. COBRA notification is sent by first-class mail within 14 calendar days of the coverage end date, which includes retirement. In the case of a divorce or the ineligibility of a child, you or your Dependent(s) must notify MassMutual Benefits or OFI Human Resources within 60 days of the COBRA qualifying event. The COBRA TPA will provide you with costs and information about how to continue COBRA coverage at the time you become eligible.

If you want to elect COBRA coverage, you must do so no later than 60 days after the date your Plan coverage ends or 60 days after the date of the notice of COBRA rights and election forms are mailed to you by the COBRA TPA, whichever is later. Payment must be made within 45 days of the date you elect COBRA.

If you elect COBRA coverage and the Social Security Administration determines that you or your Dependents were permanently and totally disabled at any time within the first 60 days of the date of continuation coverage, you or your Dependent must notify the COBRA TPA within 60 days of the determination. The notice must be received by the COBRA TPA within the initial 18 months of COBRA coverage so that you and your Dependents can qualify for an additional 11 months of coverage.

If a 36-month event happens while a Dependent is covered under COBRA, COBRA coverage may be continued for the Dependent for an additional 18 months – up to a total of 36 months.
When COBRA Ends

COBRA coverage ends when one of the following events occurs:

- The COBRA period ends (18, 29 or 36 months as defined above);
- Payment for coverage is not paid on a timely basis;
- MassMutual stops offering any group health plan;
- The person who elected COBRA becomes covered under another group health plan and meets any pre-existing condition prohibitions or limitations; or
- The person who elected COBRA becomes entitled to Medicare after COBRA coverage has started (Dependents may be eligible for continued COBRA coverage).

Trade Adjustment Assistance (TAA)

The Trade Act of 1974, as later amended by the Trade Adjustment Assistance Reform Act of 2002 and the Trade and Globalization Adjustment Assistance Act of 2009, created the Trade Adjustment Assistance (TAA) Program. This program helps individuals who have lost their jobs as a result of foreign trade. The TAA program offers a variety of benefits and services to eligible individuals, including job training, income support, job search and relocation allowances, a tax credit to help pay the costs of health insurance and a wage supplement to certain reemployed trade-affected individuals age 50 and older. For example, under the TAA Program, eligible individuals can either take a tax credit or get advance payment of a percentage of premiums paid for qualified health insurance, including COBRA coverage. If you have questions about these tax provisions, contact the Department of Labor’s Health Coverage Tax Credit Customer Service Center toll-free at 866-628-4282. TTD/TTY callers may call toll-free at 866-626-4282. Information is also available online at www.doleta.gov/tradeact.

If you qualify or may qualify for assistance under TAA, contact MassMutual Benefits or OFI Human Resources for additional information. Please be advised that you must contact MassMutual Benefits or OFI Human Resources promptly after qualifying for assistance under TAA or you may lose your special COBRA rights.

Conversion Rights

If you or your Dependents do not elect COBRA, your coverage will end. You cannot convert the coverage to an individual policy.

Portability of Coverage

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, you will receive a certificate confirming your participation in the Plan when your coverage ends. Certificates also can be obtained upon request.
Coordination of Benefits

If you or your Dependents have other coverage, in addition to your coverage under this Plan, any benefits you receive from the “other” plan will be coordinated with benefits from this Plan.

Order of Payment

When you or your Dependents are covered under more than one health plan, one plan is primary (pays benefits first) and the other plan is secondary (pays benefits second).

A plan is considered primary in the following order:

<table>
<thead>
<tr>
<th>If . . .</th>
<th>Then . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Dependent is covered under more than one plan (for example, this Plan and his or her employer’s plan)</td>
<td>The plan that covers the person as “other than a dependent” is primary.</td>
</tr>
<tr>
<td>Your child(ren) is covered under more than one plan (for example, under this Plan and your Spouse’s plan)</td>
<td>The plan of the parent whose birth date (month and day only) comes first in the calendar year is primary for your children, if both plans have a provision for the “birthday rule.” If the other plan has no “birthday rule” provision and instead has a rule based on gender of the parent, then the other plan’s rules will determine the benefits.</td>
</tr>
<tr>
<td>You are divorced and cover an eligible Dependent child</td>
<td>The Primary Plan for Eligible Dependent Children is the Plan of the:</td>
</tr>
<tr>
<td></td>
<td>• Parent that the court has decreed is responsible for the child’s health care; then</td>
</tr>
<tr>
<td></td>
<td>• Parent who has custody of the child; then</td>
</tr>
<tr>
<td></td>
<td>• Step-parent with whom the child lives; then</td>
</tr>
<tr>
<td></td>
<td>• Parent without custody.</td>
</tr>
<tr>
<td>You or your Dependents are receiving continuation coverage under federal (e.g., COBRA) or state law</td>
<td>The plan covering the person as a Participant or retiree (or that person’s dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.</td>
</tr>
<tr>
<td>None of the above circumstances apply</td>
<td>The plan that has been in force longer is the Primary Plan.</td>
</tr>
</tbody>
</table>

Note: Your Primary Plan is always this Plan, except if your Secondary Plan (your Spouse’s plan, for example) has no coordination of benefits provision.

When a plan provides benefits in the form of services, the reasonable cash value of services provided will be considered both an expense and a benefit payable.

Student Accident or Sickness Insurance Policies

The Plan does not coordinate benefits with student accident or sickness insurance policies where the student or parent pays the entire premium.
Medicare Eligibility

You and your Dependents who are eligible for Medicare may still remain eligible for coverage under this Plan, subject to MassMutual’s eligibility rules and Plan policies regarding coverage. If you are eligible for Medicare because you have end-stage renal disease (ESRD), your coverage will be administered as though you had enrolled in Parts A and B of Medicare, even if you have not enrolled in Medicare.

You or your Dependents who have Medicare receive the same Plan benefits, but the following rules determine which Plan is primary:

- **Members** who have Medicare because they are age 65 or older:
  - Medicare is the **Secondary Plan** for you and your Dependents who have Medicare when you are eligible for benefits through employment.
  - Medicare is the **Primary Plan** for you and your Dependents who have Medicare when you are not eligible for benefits through employment.

- **Members** who have Medicare due to ESRD:
  - When you or your Dependents become eligible for Medicare because of ESRD, this Plan is the **Primary Plan** for that person for a period of 30 consecutive months. This 30-month period begins on the earlier of the first day of the month during which a regular course of renal dialysis starts or the individual receives a kidney transplant.
  - After the 30-month period described above ends, Medicare is the **Primary Plan**.

  If you or your Dependents already had Medicare as the **Primary Plan** at the time of the initial dialysis treatment or kidney transplant, Medicare will remain as the **Primary Plan**.

- **Members** under age 65 who have Medicare due to a disability other than ESRD:
  - This is the **Primary Plan** for you or your Dependents when you are eligible for benefits through employment.
  - Medicare is the **Primary Plan** for you or your Dependents if you are not eligible for benefits through employment.

  Once you reach age 65, the rules described above for Members who have Medicare because they are age 65 or older apply.

Rights to Receive and Release Necessary Information

Questionnaires are routinely sent when the order of benefits among responsible plans is in question. The Plan reserves the right to deny any or all claims until the completed questionnaire has been returned.

Any person claiming services or payments must provide any information needed to implement the coordination of benefits provisions. For the purposes of implementing these provisions or a similar provision of any other plan, this Plan may, without the consent of or notice to any person, release to or obtain from any entity any information needed for such purposes to the extent permitted by law.

Facility of Payment

If another plan makes payments for services that this Plan is responsible for, this Plan may, at its sole discretion, pay to that plan any amounts the Plan determines to be warranted to satisfy the intent of this section. Amounts paid will be deemed to be services or payments under this Plan. To the extent of those payments, this Plan will be fully released from liability.
**Right of Recovery**

When payments or services have been made or arranged by the Plan in excess of the maximum for allowable expenses, no matter to whom paid, the Plan has the right to recover the excess from any persons, insurance companies or other organizations. The Plan’s right to recover any amount from you will be limited to the amount that you have received from another plan.

**Subrogation and Reimbursement**

The Plan reserves the “right of subrogation” in the event of a loss. The Plan also reserves all rights to relief under ERISA, including those based in equity. The Plan may choose to take action to recover the amount of a claim paid to you or a **Dependent** if the loss was caused by a third party. If you are injured by any act or omission of another person, the benefits under this Plan will be subrogated. This means that this Plan and your medical carrier, as this Plan’s representative, may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If you recover money, this Plan is entitled to recover up to the amount of the benefit payments that it has made. This is true no matter who or where the recovered money is held or how it is designated and even if you do not recover the total amount of your claim against the other person(s). This is also true if the payment you receive is described as payment for other than health care expenses. The amount you must reimburse this Plan will not be reduced by any attorney’s fees or expenses you incur.

You must give the Plan’s representative information and help. This means you must complete and sign all necessary documents to help the representative get this money back on behalf of this Plan. This also means that you must provide notice at all significant steps during the settlement or litigation with any third party (such as settlement, initiation of settlement, judgment, payment of judgment) and before settling any claim arising out of injuries you sustained by an act or omission of another person(s) for which this Plan paid benefits. You must not do anything that might limit this Plan’s right to full reimbursement. Your medical carrier may hold claims until information needed for review is provided.
General Provisions

- By being covered under this Plan, you and your covered Dependents accept all of the terms, conditions and provisions of this Plan.
- The claims administrator will have no liability for benefits under this Plan.
- If a person entitled to benefits is unable to care for his or her affairs because of illness, accident or incapacity (either physical or mental), payment that would otherwise be made to that person will be made to that person’s duly appointed legal representative. If no legal representative has been appointed, payment will, at the discretion of the Plan Sponsor, be made to that person’s Spouse, child or such person who has care and custody of that person.
- The benefits of this Plan are not transferable and may not be assigned to any third party, except when you indicate on the claim form that payment should be sent directly to the provider of the Covered Service or when an ambulance company provider is entitled to be paid directly by the Plan pursuant to applicable law.
- The Plan Administrator (or carrier) may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Plan.
- If any portion of this Plan is or becomes, for any reason, invalid or unenforceable, that portion will be ineffective only to the extent of the invalidity or unenforceability and the remaining portion or portions will nevertheless be valid, enforceable and of full force and effect.
- This Plan will be governed by and construed in accordance with the Employee Retirement Income Security Act (ERISA) and any applicable state laws.
- Participating Providers are not employees or agents of the claims administrator. They are independent contractors with the responsibility for determining and providing health care for their patients.
- The claims administrator is not responsible for your decision to receive treatment, service or supplies provided by Participating Providers, nor is the claims administrator responsible or liable for the treatment, services or supplies provided by Participating Providers.
- This Plan does not limit coverage for conditions just because you had the condition before you became covered under the Plan.
- This Plan calculates benefits on a calendar-year basis, which is the same as the Plan Year.
- You and the Plan Sponsor agree to cooperate with the claims administrator and to follow the claims administrator’s policies, procedures and instructions in all administrative matters required for the orderly administration of the Plan.

Women’s Health and Cancer Rights Act

The Plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These services will be provided in a manner determined in consultation with you and your attending physician. They will be covered the same as any other medical/surgical benefit under the Plan.
Newborns’ and Mothers’ Health Protection Act

As required by the Newborn’s and Mothers’ Health Protection Act, the Plan will not 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. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, it is not required that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay of no more than 48 hours (or 96 hours).

Primary Care Providers

The Plan generally allows the designation of a Primary Care Provider. You have the right to designate any Primary Care Provider who participates in the CIGNA network and who is available to accept you or your family members. For information on how to select a Primary Care Provider, and for a list of the participating Primary Care Providers, contact the CIGNA (see the Contact Information section).

For children, you may designate a pediatrician as the Primary Care Provider.

You do not need prior authorization from CIGNA or from any other person (including a Primary Care Provider) to obtain access to obstetrical or gynecological care from a CIGNA network professional who specializes in obstetrics or gynecology. However, the health care professional may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. Contact CIGNA for a list of participating health care professionals who specialize in obstetrics or gynecology.
Administrative Information

Qualified Medical Child Support Order (QMCSO)

Special rules apply when a court issues a QMCSO requiring you to provide health coverage for an Eligible Dependent Child. The Plan Administrator will decide whether you may enroll the children because of a QMCSO, and your medical carrier will follow this decision.

Note: Except as otherwise noted in this document, both you and your Dependents must be covered by the same option.

You or your Dependents can obtain procedures for QMCSO determinations at no charge by contacting OFI Human Resources or MassMutual Benefits.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality and privacy of individually identifiable health information. A description of a Member’s HIPAA privacy rights is found in the Notice of HIPAA Privacy Practices: MassMutual Health Plans, which has been distributed to Plan Participants. This Notice is also available on OPNet, myHR and MMInfo/Personal Resources/Benefits.

The Plan and those administering it will use and disclose health information only as allowed by federal law. If you or any Member has a complaint, questions, concerns or requests a printed copy of the Notice of HIPAA Privacy Practices: MassMutual Health Plans, you may contact the Compliance Officer in the Plan Administrator’s office.

Massachusetts Health Insurance

All Massachusetts residents older than age 18 must have a certain minimum level of health insurance, or face financial consequences. Adult residents must show proof of coverage to the state or they will be subject to a tax penalty, which is subject to change.

If you are eligible for coverage through the Company, you can only join the Plan during Annual Benefits Enrollment unless you have a Qualified Change in Status (i.e., marriage, divorce, loss of coverage, death of Spouse, birth, adoption, etc.). Please contact OFI Human Resources or MassMutual Benefits for more information.

The Commonwealth of Massachusetts requires the Company to report employees without health coverage to the state. If you do not enroll in a health insurance option offered by the Company, you will receive a Health Insurance Responsibility Disclosure (HIRD) form. Fill out the HIRD form (simply follow the directions on the form), as soon as possible each time you are requested to complete one.
For Massachusetts residents, you may be eligible for coverage through The Health Connector if:

- You are scheduled to work more than 64 hours per month and are not eligible for the Company’s plan;
- You are eligible for health insurance through the Company but declined it and have no other coverage;
- Your eligible child, over the age of 18, is no longer eligible for coverage under the Company’s plan; or
- You or your Dependents do not elect COBRA upon loss of coverage.

For a list of state-approved health insurance options that comply with the law, access The Health Connector at www.mahealthconnector.org or call 877-MA-ENROLL (877-623-6765).
Plan Information

The information presented in this SPD is intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974.

Plan Name and Number

MassMutual Employee Welfare Benefits Plan, 503

Plan Administrator

The Plan Administrator is the Plan Administrative Committee, which is appointed by MassMutual’s Chief Executive Officer. The Plan Administrative Committee has the authority to control and manage the operations and administration of the Plan. You can reach the Plan Administrative Committee at:

Massachusetts Mutual Life Insurance Company
MassMutual Benefits
1295 State Street, F105
Springfield, MA 01111-0001
866-662-6448

Plan Sponsor

Massachusetts Mutual Life Insurance Company
1295 State Street, F105
Springfield, MA 01111-0001
866-662-6448

Employer Identification Number (EIN)

The EIN of Massachusetts Mutual Life Insurance Company is 04-1590850.

Plan Year

The Plan Year is January 1 through December 31.

Agent for Service of Legal Process

General Counsel of Massachusetts Mutual Life Insurance Company
1295 State Street
Springfield, MA 01111-0001

If legal action is necessary to settle a claim, any action may also be served upon the Plan Administrator.
Plan Type and Funding

This Plan is a welfare plan providing medical, behavioral health and prescription drug benefits on a self-funded basis. All contributions are made to the MassMutual Employee Health Benefits Trust (the “Trust”) and Trust assets are used to fund Plan benefits. Both Company and Participant contributions are applied to the Trust. The Trustee of the Trust is The MassMutual Trust Company.

Claims Administrator

The claims administrator for medical (including behavioral health) coverage is CIGNA Healthcare. The claims administrator for prescription drug coverage is Express Scripts, Inc. Refer to the Contact Information section for details. The claims administrator has full discretion and fiduciary authority to determine claims and appeals arising under this Plan.

Type of Administration

This Plan is administered by a third-party administrator. The third-party administrator for medical benefits is CIGNA. The third-party administrator for prescription drug benefits is Express Scripts, Inc. Refer to the Contact Information section for details.

Continuation of the Plan

At this time, the Company expects to continue sponsoring the Plan. However, the Company reserves the right to terminate, modify, amend or suspend the benefit plans, in whole or part, at any time and from time to time without advance notice. This may result in modification or termination of benefits to Participants. You will be notified, in writing, of any change or if the benefit ends.
As a Plan Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. ERISA provides that you are entitled to the rights described in this section.

Receive Information about Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator’s office or other specified locations, such as worksites, all documents governing the Plan. These include any insurance contracts and copies 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 (EBSA).
- Obtain, upon written request, copies of documents governing the operation of the Plan. These include any insurance contracts and copies of the latest annual report (Form 5500 series) and current Summary Plan Description. A reasonable charge may be required for the copies.
- Receive a summary of the Plan’s annual financial report (summary annual report), which is required by law to be provided to each Member.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself and your dependents if there is a loss of coverage as a result of a qualifying event. You or your dependents may have to pay for this coverage. You will be provided with more information regarding your COBRA coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under a group health plan if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from the Plan when:
  - You lose Plan coverage, including the loss of coverage due to reaching an overall Plan lifetime maximum;
  - You become entitled to elect COBRA coverage; or
  - Your COBRA coverage ends.
  You may request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called Plan fiduciaries, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including the Company or any other person, may discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, 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. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan’s claim and appeal procedures.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of a Plan document or the latest annual report and do not receive it 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 Plan Administrator’s control.

If you have a claim that 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 medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan’s money or if you believe that you have been 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 if, for example, it finds your claim is frivolous.

Assistance with Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about your rights under ERISA or if you need assistance in getting documents from the Plan Administrator, you should contact the nearest EBSA office or the national office at:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
866-444-3272

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact EBSA by visiting their website at www.dol.gov/ebsa.
Dictionary Terms

After-Tax or Post-Tax

Contributions taken after applicable federal, state and/or local taxes are withheld.

Allowable Expense

A necessary, reasonable and customary service or expense, including Deductibles, Coinsurance or Copayments, that is covered in full or in part by any plan covering you. When a plan provides benefits in the form of services, the reasonable cash value of each service is the Allowable Expense and is a paid benefit.

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

- An expense or service or a portion of an expense or service that is not covered by any of the plans is not an Allowable Expense.
- If you are confined to a private hospital room and no plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one plan that provides services or supplies on the basis of reasonable and customary fees and one plan that provides services and supplies on the basis of negotiated fees, the Primary Plan’s fee arrangement will be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher Copayment amount, higher Coinsurance percentage, a Deductible and/or a penalty) because you did not comply with plan provisions or because you did not use a Preferred Provider, the amount of the reduction is not an Allowable Expense. Such plan provisions include second surgical opinions and Pre-Authorization of admissions or services.

Annual Benefits Enrollment, Benefits Enrollment or Open Enrollment

The period each year, typically in the fall, designated by the Company when you may make changes to your benefit elections. Changes are effective the following January 1.

Before-Tax or Pre-Tax

Contributions taken before applicable federal, state and/or local taxes are withheld.

Benefit Maximum

The maximum amount the Plan will pay.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this Plan or any date before this provision or any similar provision takes effect.
Coinsurance

The percent of charges that you and the Plan will pay for Covered Services.

Covered Benefits or Covered Services

Health care services or supplies for which this Plan provides benefits.

Custodial Care

Any services that are of a sheltering, protective or safeguarding nature. These services may include a stay in an institutional setting, at-home care or nursing services to care for someone because of age or mental or physical condition. Custodial Care primarily helps the person in daily living and can also provide medical services, given mainly to maintain the person’s current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial services include, but are not limited to, services:

- Related to watching or protecting a person;
- Related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods or taking medications that can be self administered; and
- Not required to be performed by trained or skilled medical or paramedical personnel.

Deductible

The annual amount you must pay before the Plan begins to pay most benefits.

Dependents

Eligible Dependents include:

- Your Spouse (not including an ex-Spouse);
- Your Domestic Partner, as defined below by the Plan;
- Your Eligible Dependent Child(ren) (see the Eligible Dependent Children section); and
- For residents of U.S. jurisdictions where same-sex marriage is recognized, your eligible same-sex Spouse and eligible children of your same-sex Spouse.

MassMutual reserves the right to verify a Dependent’s eligibility status for Plan coverage at any time, or from time to time.

Domestic Partner

An eligible Domestic Partner is someone of the same or opposite sex who:

- Has lived together with you as a domestic partner for at least 12 consecutive months before enrollment in the Plan;
- Is at least 18 years old;
- Is not legally married to or separated from anyone else;
- Is not related any closer than would make a marriage illegal;
- Is your sole domestic partner and intends to remain so indefinitely;
- Shares financial responsibilities and expenses with you; and
- Has resided together with you as if married and intends to do so indefinitely.
Effective Date

The date coverage begins.

Eligible Dependent Children

The following children, without further requirement, through the end of the month in which the child turns age 26, are eligible:

- Your son;
- Your daughter;
- Your stepson;
- Your stepdaughter;
- Legally adopted;
- Lawfully placed with you for legal adoption; or
- A foster child placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

Additional Eligible Dependent Children

In addition, Eligible Dependent Children include:

- A child for whom you are the legal guardian (Note: Generally, legal guardianship ends at age 18);
- A child for whom the court has issued a Qualified Medical Child Support Order (QMCSO); and
- Your Domestic Partner’s child, if your Domestic Partner is covered under the Plan.

For any of the additional Eligible Dependent Children listed above to be covered, the child must:

- Be covered under your Plan before age 19;
- If older than age 18 (up to age 25), be a student enrolled in an accredited two- or four-year college or university (undergraduate or graduate program) or a post-high school trade or technical school on a full-time basis, as defined by the school’s regulations for full-time students;
- Not be an active member in the armed forces;
- Not be employed on a full-time basis;
- Not be married; and
- Be your IRS tax dependent.

In addition to the above requirements, any additional Eligible Dependent Child’s principal residence must be the same as your residence for six or more months of the calendar year. However, full-time student’s principal residence is considered to be his/her parent’s address, even if living on- or off-campus.

Inpatient Care or Inpatient Services

Services you receive while admitted to the hospital and directed to stay for at least 24 hours.
**Maximum Reimbursable Charge**

The lesser of:
- The provider’s normal charge for a similar service or supply; or
- The 80th percentile of charges made by providers of the service or supply in the geographic area where it is received (using a database selected by CIGNA).

**Medically Necessary or Medical Necessity**

Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
- In accordance with the generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
- Not primarily for the convenience of the patient or physician, or other physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

Generally accepted standards of medical practice means:
- Standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community;
- Physician specialty society recommendations;
- The views of physicians practicing in the relevant clinical area; and
- Any other relevant factors.

**Member or Participant**

A person enrolled in and covered by this Plan, including you and your eligible Dependents.

**Order of Benefit Determination Rules**

When you or your Dependents are covered under more than one health plan, one plan is primary (pays benefits first) and the other plan is secondary (pays benefits second). See the Coordination of Benefits section for more information.

**Out-of-Pocket Maximum**

The maximum annual amount you are required to pay before the Plan pays 100% for most Covered Services.

**Outpatient Care or Outpatient Services**

Services you receive from a hospital or other provider without being admitted, such as X-rays, physical therapy or laboratory testing.

**Participating Provider, Preferred Provider, or In-Network Provider**

A hospital, physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with the carrier to provide Covered Services at negotiated rates for Members covered under the Plan.
Plan Year

A period commencing on the Effective Date of the Plan or on any subsequent plan anniversary and continuing through the last day preceding the next succeeding Plan anniversary. For this Plan, the Plan Year is the 12-month period from January 1 to December 31.

Pre-Authorization or Pre-Authorized

The approval that a Participating Provider must receive from the review organization before providing services for certain services and benefits to be covered.

Primary Care Physician, Primary Care Provider or PCP

A physician who manages your care and refers you to specialists within the network when necessary.

Primary Plan

The plan that, under coordination of benefits provisions, covers you first when you have coverage under more than one plan.

Qualified Change in Status

Any change to your medical option due to a Qualified Change in Status must be consistent with and on account of the Qualified Change in Status. If you have a Qualified Change in Status, you can change your existing level of medical coverage (e.g., changing from individual to family coverage) or you may be able to enroll in coverage for the first time if you previously waived coverage. You must make any changes and provide documentation within 30 days of your Qualified Change in Status. For more information, see the Qualified Change in Status section.

Qualified Medical Child Support Order or QMCSO

A judgment, decree or order that meets all of the following criteria:

- Is issued by a court pursuant to a domestic relations law or community property law
- Creates or recognizes the right of an alternate recipient to receive benefits under a parent’s group health plan
- Includes certain information relating to the Participant and alternate recipient

Reasonable and Customary or R&C

See Maximum Reimbursable Charge.

Secondary Plan

The plan that, under coordination of benefits provisions, covers you after another plan when you have coverage under more than one plan. See the Coordination of Benefits section for more information.

Service Area or Network Area

The geographic area in which the carrier has an adequate network established to provide the services covered under the Plan.
Spouse
Your legally married husband or wife.

Note: If you have a same-sex Spouse and reside in a U.S. jurisdiction in which it is recognized, federal and state tax treatment may vary.

Terminal Illness or Terminally Ill
A prognosis of six months or fewer to live, as diagnosed by a physician.

Urgent Care
Medical, surgical, hospital or related health care services and testing that are not emergency services, but that are determined by CIGNA, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention.