MassMutual Agents’ Welfare Benefits Plan
High Deductible Health Plan (HDHP)
Option 1 and Option 2
Medical Summary Plan Description
for Career Agents, General Agents and General Managers of
MassMutual

Effective January 1, 2014

This Summary Plan Description (SPD), published in October 2014, takes the place of any SPDs and Summaries of Material Modifications (SMMs) previously issued to you describing your benefits.
Disclaimer

This Summary Plan Description (SPD) provides details of the medical options available through the MassMutual Agents’ Welfare Benefits Plan (the “Plan”). This SPD contains detailed and important information about the Plan’s medical options; 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. 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. To be entitled to benefits, you (and your dependents) must meet the Plan’s eligibility requirements.

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 information in relevant Plan documents, the Plan documents will govern.

Career contract and general agents are independent contractors; provision of benefits does not change that relationship.
**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(s), including who is eligible, how the Plan works, and what is and is not covered.
Eligibility

Eligible Participants

You are eligible for medical coverage under the Plan if you have an active career agent, general agent (GA) or general manager (GM) contract with or endorsed by MassMutual. Throughout this SPD, unless noted otherwise, any reference to agent or contract references you or your contract.

Production Requirements for Subsidized Coverage

As a career contract agent, to be eligible for subsidized medical benefits, each year you must satisfy certain contract requirements:

- **Non-Financed Career Contract Agent**: Annual contract minimum requirements;
- **Financed Career Contract Agent**: Cumulative financing plan validation requirements; or
- **Sales Manager/Unit Sales Manager**: Annual sales manager compensation plan requirements.

These requirements, updated from time to time, are available in Company memoranda on FieldNet. For a career contract agent receiving disability benefits under the MassMutual Agents’ Welfare Benefits Plan, continued eligibility requirements for coverage are currently described in Company Memorandum 2013-021, *Contract and Benefit Production Requirement Exceptions for Disabled Agents* (or its successor), available on FieldNet.

If You Do Not Meet Production Requirements

If you are an eligible non-financed career contract agent and do not meet the annual contract minimum requirements, your subsidized coverage can continue until March 31 of the following year, provided your contract remains active.

If you continue to hold a career agent contract and you are unsubsidized, you may continue coverage at unsubsidized rates with After-Tax contributions. Unsubsidized agents can request to drop their medical coverage at any time between April 1 and the end of the year by notifying Producer Services & Operations. These requested changes will be effective the first of the month after Producer Services & Operations receives the request via email or telephone.

You may re-qualify for subsidized benefits on a Before-Tax basis if you meet certain production requirements during the calendar year. Once the requirements are met, subsidized benefits will begin the first of the month following qualification.

If your career agent contract is terminated, based on your medical coverage in place immediately before the date your contract is terminated, you may elect to continue medical coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA); this election must be completed within 60 days after you are notified of your COBRA rights; see the COBRA section for more information.

Note: Under the most recent career corporate contract, subagents of an entity are not eligible for participation in any Company retirement, welfare or other benefit plan or program offered by the Company (as described in Company Memorandum 2011-004).
Ineligible Individuals

You are not eligible for Plan coverage if you are:

- A broker (or individual with any type of contract except a career agent or general agent);
- A retired agent of the Company (certain retired agents may be eligible for retiree benefits based on age and service requirements; contact Producer Services & Operations for more information);
- An agency staff member;
- An agent otherwise excluded by Plan terms; or
- An employee of MassMutual or one of its subsidiaries (exception: general managers).

Eligible Dependents

You may cover your eligible Dependents, which include your:

- Current Spouse (same-sex or opposite-sex, not including an ex-Spouse) or Domestic Partner, as defined by the Plan; and
- Eligible Dependent Child(ren), as defined by the Plan.

Notes:

- For residents of U.S. jurisdictions where same-sex marriage is recognized, the value of coverage for your same-sex Spouse is not included as income for federal or state tax purposes.
- For residents of U.S. jurisdictions where same-sex marriage is not recognized, the value of coverage for your same-sex Spouse is not included as income for federal tax purposes, but may be included as income for state tax purposes.
- The value of coverage for your Domestic Partner is included as income for federal and state tax purposes, if appropriate.
- Eligible Dependent Children of a same-sex Spouse/Domestic Partner generally are treated in the same manner as the same-sex Spouse/Domestic Partner 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, by requiring you to provide supporting documentation. Failure to provide supporting documentation may result in loss of coverage.

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 in such a way that would make a marriage illegal in your state of residence;
- 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 one form of supporting documentation to apply for coverage for your Domestic Partner.
If your domestic partnership terminates, you must submit a signed *Termination of Domestic Partnership* form to remove a **Domestic Partner** from your coverage within 30 days of the termination of 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 **Spouse**.

The above forms are available online at FieldNet/My Practice/Benefits/myBenefits/Forms.

**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;
- Your legally adopted child;
- A child 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.

**Note:** As of January 1, 2010, Michelle’s Law allows an otherwise eligible **Dependent** child 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 Producer Services & Operations to request this form.

**Important Notes**

- A **Dependent** child with a mental or physical disability may be 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. Medical carrier certification and approval are required. For more information, contact Producer Services & Operations.
- 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 Producer Services & Operations 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, but you must enroll the child to ensure that he or she is covered. To enroll, you must notify Producer Services & Operations within 90 days of your child’s birth. If notification is not received within 90 days, the child cannot be added to the Plan until the next **Annual Benefits Enrollment** period or applicable/appropriate **Mid-Year Qualifying Event**. You must provide a copy of the child’s birth certificate or live birth record with your notification.
• 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 Producer Services & Operations within 90 days of adoption or placement for adoption. If notification is not received within 90 days, the child cannot be added to the Plan until the next Annual Benefits Enrollment period or applicable/appropriate Mid-Year Qualifying Event.

• If you and your Spouse are both eligible agents, you can cover your Spouse as a Dependent under your Plan, your Spouse can cover you as a Dependent under his or her Plan or both you and your Spouse can separately elect agent coverage. However, please note that neither of you can be covered as both an agent and a Dependent under the Plan. In addition, if one agent covers both agents and that agent terminates his or her contract, the other agent may pick up coverage, but will need to begin a new Deductible.

• If you and your Spouse are both eligible agents, only one of you can cover your child(ren) as a Dependent(s) 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 agents, 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, if eligible as an agent. However, you cannot cover your child as a Dependent at the same time that he or she receives coverage independently under the Plan (i.e., your child cannot be covered as both an agent and as your Dependent).

• 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 if you are currently enrolled or will enroll in 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 Producer Services & Operations.

• If you or a Dependent lose coverage under the Plan and become entitled to elect Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage (see the COBRA section for more information and timing), you or your Dependent(s) must notify Producer Services & Operations within 60 days of the COBRA qualifying event (you will have 60 days in which to make an election) or you may lose your right to elect COBRA. MassMutual’s COBRA third-party administrator 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 contract endorsement date 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.

In addition, if you have a Mid-Year Qualifying Event, you may be eligible to elect, change or drop coverage during the Plan Year. You must contact Producer Services & Operations within 30 days of your Mid-Year Qualifying Event (90 days in the case of birth, adoption or placement for adoption) to make changes to your coverage. Refer to the Mid-Year Qualifying Event section.

When Coverage Begins

Initial Eligibility

Your and your eligible Dependents’ medical coverage is effective as of your contract endorsement date. 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 enrollment for 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 Mid-Year Qualifying Event; see the Mid-Year Qualifying Event 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 the Annual Benefits Enrollment period 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, you or your Dependent(s) will not be eligible to continue coverage under COBRA; changes made during Annual Benefits Enrollment are not considered COBRA qualifying events.

Mid-Year Qualifying Event

If you have a Mid-Year Qualifying Event, you may be able to change your existing level of medical coverage (e.g., change from individual to family coverage), enroll in coverage for the first time if you previously waived coverage or drop coverage. Any change to your medical coverage due to a Mid-Year Qualifying Event must be consistent with the Mid-Year Qualifying Event under the Plan and the tax rules.
Mid-Year Qualifying Events include:

- A loss of other coverage (either from exhausting COBRA or from losing eligibility under another employer’s health plan);
- A change in your legal marital status, such as marriage, the death of a Spouse, divorce or legal annulment;
- A change in the number of your Dependents, due to birth, death, adoption or placement for adoption;
- A change in your, your Spouse’s or your Dependent’s employment status (such as a termination or commencement of employment, a strike or lockout, commencement or return from a leave of absence, a change in worksite or a change in employment status that results in a loss or gain of eligibility for coverage);
- Your Dependent becomes eligible or ineligible (e.g., due to age);
- A change in your, your Spouse’s or your Dependent’s residence that affects coverage;
- A judgment, decree or order resulting from a divorce, legal annulment or change in legal custody that requires coverage for your child or foster child;
- You, your Spouse or Dependent becomes entitled to or loses eligibility for Medicare Part A or B or Medicaid;
- Certain “significant” cost or coverage changes under the Plan (only as permitted by the tax rules);
- A change in coverage under another employer’s plan (for example, if your Spouse’s plan has a different annual enrollment period);
- You or your Dependent loses eligibility for a state Children’s Health Insurance Program (CHIP) or becomes eligible for a state CHIP subsidy; and
- Loss of coverage under a governmental or educational institution group health plan (e.g., state CHIP, an Indian Tribal government, the Indian Health Service or a tribal organization, a state health benefits risk pool or a foreign government group health plan).

Changes you make due to a Mid-Year Qualifying Event become effective as of the date of your Mid-Year Qualifying Event. 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., change from individual to individual plus Spouse coverage) due to a Mid-Year Qualifying Event, you must notify Producer Services & Operations and provide appropriate documentation within 30 days of the date of the event (90 days in the case of birth, adoption or placement for adoption). A Mid-Year Qualifying Event may allow you to change your coverage level, but you cannot change your medical options within the Plan Year.

Special Enrollment Rules

Loss of Other Coverage or Gain of a Dependent

If you do not elect medical coverage for yourself and/or your eligible Dependents (including your Spouse) because you have other medical coverage, you may enroll yourself and your eligible Dependents in the Plan if you or your Dependent(s) loses eligibility for other coverage or the other employer ceases to make employer contributions for the other coverage. However, you must request enrollment within 30 days of losing the other coverage or after the employer stops contributing to the other coverage. You will need to provide documentation with your request. Plan coverage will be effective as of the date of the loss of other medical coverage or the date the other employer ceases to make employer contributions for the other coverage.

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 marriage or 90 days after birth, adoption or placement for adoption. Coverage will be effective as of the date of 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)** was covered under a Medicaid Plan or state CHIP and that coverage terminated due to a loss of eligibility; or
- You or your **Dependent(s)** becomes 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. Plan coverage will be effective as of the date of the loss of Medicaid or CHIP coverage or the date of the eligibility determination.
Cost of Coverage

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

Your contributions are deducted from your commission voucher on a Before-Tax basis, with the following exceptions:

- For eligible corporate agents, the full amount of coverage is deducted on an After-Tax basis from your corporate commission voucher; the value of the Company subsidy is paid through the same voucher and appears as an adjustment.
- For general agents and general managers, contributions are taken on an After-Tax basis (if you elect this coverage. General agents’ contributions for medical coverage are subject to imputed income. This means the amount of Company subsidy for medical coverage is included as income for federal tax purposes.
- For unsubsidized agents, contributions are taken on an After-Tax basis.

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

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

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

Tobacco Surcharge

If you or any Dependent covered under a MassMutual medical option uses any tobacco product, your cost of coverage will be higher as follows:

- $400 more per year if you cover yourself only;
- $800 more per year if you cover yourself plus:
  - Your Spouse/Domestic Partner; or
  - Your child(ren); or
- $1,200 more per year if you cover yourself, your Spouse/Domestic Partner and child(ren).

Note: This surcharge is not applicable to unsubsidized agents.

Imputed Income

If you elect medical coverage for your Domestic Partner, you will be responsible for “imputed income.” This means that the fair market value of the coverage for your Domestic Partner (and any coverage for your Domestic Partner’s eligible Dependents) will be considered income for federal tax purposes (state taxes may also apply in states that do not recognize domestic partners). 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 not be included as income for federal or state tax purposes. However, for same-sex married couples living in U.S. jurisdictions that do not recognize same-sex marriage, the value of medical coverage for a same-sex Spouse and his or her eligible Dependents will not be included as income for federal tax purposes, but may be included as income for state 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.

Consult your tax advisor for more information.
# Contact Information

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<tr>
<th>Resource</th>
<th>Participant Website</th>
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<td><a href="http://www.myCigna.com">www.myCigna.com</a></td>
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<td>Benefit Concepts, a division of WageWorks</td>
<td><a href="https://mybenefits.benefitconcepts.com">https://mybenefits.benefitconcepts.com</a></td>
<td>866-629-6350</td>
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<td>(COBRA and FSA Administrator and Enrollment</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>Producer Services &amp; Operations</td>
<td>Website: <a href="https://benedirect.massmutual.com/irj/portal">https://benedirect.massmutual.com/irj/portal</a> Email: <a href="mailto:AgentBenefitQuestions@MassMutual.com">AgentBenefitQuestions@MassMutual.com</a></td>
<td>800-767-1000 or Ext. 48850, business days, 8 a.m.- 6 p.m., ET</td>
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How the Plan Works

You can choose between two High Deductible Health Plan (HDHP) options. Both Option 1 and Option 2 cover the same services and allow you to visit any licensed provider in the country. These options differ only in the amount you pay toward your Deductible and Out-of-Pocket Maximum as well as your per commission voucher contributions towards the cost of coverage.

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 applies. The Plan covers these services in full. You pay $0 for eligible preventive services from Participating (In-Network) Providers. Costs for preventive services from Non-Participating (Out-of-Network) Providers are subject to Maximum Reimbursable Charges.
- **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, colonoscopy prep and birth control prescriptions are 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 commission voucher contributions and any amount over the Maximum Reimbursable Charge, 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, and if you are a subsidized agent, 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 Producer Services & Operations.
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, colonoscopy prep and birth control prescriptions 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, subject to Maximum Reimbursable Charges when provided by a Non-Participating (Out-of-Network) Provider. Using preventive services and following recommended health guidelines can help keep you and your family stay 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 any applicable Deductible and Coinsurance. The doctor’s coding of the claim determines if care will be covered as preventive. For more information about which services are considered preventive care, see the Schedule of Benefits and Preventive Care sections.

Some medications are also classified as preventive. 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. The Maximum Reimbursable Charge is determined based on the lesser of:

- The provider’s normal charge for a similar service or supply; or
- A percentage of a fee schedule that Cigna developed based on a methodology similar to a methodology used by Medicare to determine the allowable fee for similar services within the geographic area.

In some cases, a Medicare-based fee schedule is not used and the Maximum Reimbursable Charge for Covered Services is determined based on the lesser of the:

- Provider’s normal charge for a similar service or supply; or
- Amount charged for that service or supply by providers in the geographic area where the service or supply is received.

Note: The Out-of-Network Provider may bill you for the difference between the provider’s normal charge and the Maximum Reimbursable Charge, as determined by the Plan, in addition to any applicable Deductible and/or Coinsurance.

Participating (In-Network) Providers

When you use a Participating (In-Network) Provider, your out-of-pocket costs are generally lower because Participating (In-Network) Providers have agreed to negotiated fees with Cigna. Participating (In-Network) 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 (In-Network) Providers in your area.
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. The Plan does not require that you select a PCP or get a referral from a PCP to receive the benefits available to you under this Plan. However, a PCP can serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, you are encouraged to use a PCP and you have the opportunity to select a PCP from a list provided by Cigna, for yourself and your Dependents. 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. You and your Dependents are allowed direct access to Participating (In-Network) 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 (In-Network) 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 (In-Network) Provider can help you with this process.

Changing PCPs

You may request a transfer from one PCP to another by contacting Cigna member services at the number on your ID card. Any transfer is effective as of the first day of the month following the month in which the change is processed.

In addition, if at any time a PCP stops being a Participating (In-Network) Provider, Cigna will notify you or your Dependent in writing for the purpose of selecting a new PCP, if you choose.

Special Plan Provisions

Pre-Authorization

Pre-Authorization means the approval that a Participating (In-Network) Provider must receive from the Review Organization before certain services are provided.

In general, Participating (In-Network) 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 Facility Services;
- Advanced radiological imaging;
- Non-emergency ambulance; and
- Transplant services.

If you do not use a Participating (In-Network) Provider, it is your responsibility to request Pre-Authorization before any Hospital inpatient admission or outpatient procedure/diagnostic testing.

Pre-Admission Certification – Continued Stay Review (PHS+)

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent requires treatment in a Hospital:

- As a registered bed patient;
- For a partial hospitalization for mental health or substance abuse treatment;
• For the treatment of substance abuse in a substance abuse intensive outpatient therapy program; and
• For mental health or substance abuse residential treatment services.

You or your Dependent should request PAC before any non-emergency treatment in a Hospital described above. For an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested before the end of the certified length of stay for continued Hospital Confinement.

You are responsible for contacting Cigna:
• A $500 penalty applies to Hospital inpatient charges for failure to contact Cigna to Pre-Certify an inpatient admission.
• Benefits are denied for any admission reviewed by Cigna that is not certified.
• Benefits are denied for any additional days that are not certified by Cigna.

Note: Cigna’s PAC/CSR is not necessary for Medicare primary individuals.

Covered expenses incurred will not include the first $500 of Hospital charges made for each separate admission to the Hospital unless PAC is received:
• Before the date of admission; or
• For an emergency, within 48 hours after the date of admission.

Payment for the following will be reduced under the following conditions when PAC is not received before the date of the admission, or, for an emergency admission, within 48 hours after the date of the admission:
• Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
• Any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, expenses incurred for which payment is excluded by the above terms will not be considered as expenses incurred for any other part of this Plan, except for coordination of benefits.

Outpatient Certification Requirements for Out-of-Network

Outpatient certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-Standing Surgical Facility, Other Health Care Facility or Physician's office. You or your Dependent should call the toll-free number on the back of your ID card to determine if outpatient certification is required before any outpatient diagnostic testing or procedures. Outpatient certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient certification should only be requested for nonemergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) before having the procedure performed or the service rendered.

You are responsible for contacting Cigna:
• A $500 penalty applies to outpatient diagnostic testing or procedures charges for failure to contact Cigna to Pre-Certify before the date of the testing or procedure is performed.
• Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna and not certified.
Covered Expenses incurred will not include the first $500 for charges made for any outpatient diagnostic testing or procedure performed unless outpatient certification is received before the date the testing or procedure is performed.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which outpatient certification was performed, but, which was not certified as Medically Necessary.

In any case, expenses incurred for which payment is excluded by the above terms will not be considered as expenses incurred for any other part of this Plan, except for coordination of benefits.

**Diagnostic Testing and Outpatient Procedures**

Include, but are not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Hysterecotomy.

**Cigna’s Toll-Free Care Line**

Cigna’s toll-free care line allows you to talk to a health care professional 24 hours a day, 7 days a week, 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 (In-Network) Providers. If you or your Dependent(s) needs medical care, you may consult the Participating (In-Network) Provider list online at www.mycigna.com, which lists the Participating (In-Network) Providers in your area, or call Cigna’s toll-free number for assistance. You may have access to a national network of Participating (In-Network) Providers through Cigna’s Away-From-Home Care feature. Call Cigna’s toll-free care line for the names of Participating (In-Network) Providers in other Network Areas. Whether you obtain the name of a Participating (In-Network) 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 (In-Network) Provider.

**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 a percentage of the surgeon’s allowable charge, as specified in Cigna reimbursement policies. (For 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 for charges made by co-surgeons will be limited to the amount specified in Cigna reimbursement policies. Contact Cigna for more information.
Schedule of Benefits

Notes:

- The differences between Option 1 and Option 2 are the calendar year **Deductibles** and **Out-of-Pocket Maximums**, as shown below. The option you are covered under is based on the option you elected when you enrolled for coverage.
- See the **Dictionary Terms** section for more information on the terms used to describe Plan benefits.
- Refer to the **Prescription Drug Addendum** for information about prescription drug coverage.
- **Maximum Reimbursable Charge (MRC):** MRC is determined based on the lesser of:
  - The provider’s normal charge for a similar service or supply; or
  - A percentage of a fee schedule developed by Cigna that is based on a methodology similar to a methodology used by Medicare to determine the allowable fee for the same or similar services within the geographic area.
  
  In some cases, a Medicare-based fee schedule is not used and the MRC for **Covered Services** is determined based on the lesser of the:
  - Provider’s normal charge for a similar service or supply; or
  - Amount charged for that service or supply by 80% of providers in the geographic area where the service or supply is received.

- **Out-of-Network Providers** may bill you for the difference between the provider’s normal charge and the MRC, in addition to any **Deductible** and/or **Coinsurance**.

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%, subject to MRC</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual: $1,300</td>
<td>Individual: $1,300</td>
<td></td>
</tr>
<tr>
<td>Family: $2,600</td>
<td>Family: $2,600</td>
<td></td>
</tr>
<tr>
<td>Option 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual: $2,500</td>
<td>Individual: $2,500</td>
<td></td>
</tr>
<tr>
<td>Family: $5,000</td>
<td>Family: $5,000</td>
<td></td>
</tr>
</tbody>
</table>

- The amount you pay for all **Covered Services** counts toward both your in-network and out-of-network **Deductibles**
- If you have individual coverage, after you meet your individual **Deductible**, the Plan begins to pay **Coinsurance** for **Covered Services**
- If you have family coverage, after you and your family meet the family **Deductible**, the Plan begins to pay **Coinsurance** for **Covered Services** for all eligible family members
- The **Deductible** is a combined medical and prescription drug **Deductible**
Plan Features

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Out-of-Pocket Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 1</td>
<td>Individual: $3,000</td>
<td>Individual: $3,000</td>
</tr>
<tr>
<td></td>
<td>Family: $5,000</td>
<td>Family: $5,000</td>
</tr>
<tr>
<td>Option 2</td>
<td>Individual: $4,500</td>
<td>Individual: $4,500</td>
</tr>
<tr>
<td></td>
<td>Family: $9,000</td>
<td>Family: $9,000</td>
</tr>
</tbody>
</table>

- The amount you pay for all Covered Services counts toward both your in-network and out-of-network Out-of-Pocket Maximums.
- Plan Deductibles and Copayments count towards your Out-of-Pocket Maximum.
- If you have individual coverage, after you meet your individual Out-of-Pocket Maximum, the Plan pays 100% of Covered Services for the remainder of the year.
- If you have family coverage, after you and your family meet the family Out-of-Pocket Maximum, the Plan pays 100% of Covered Services for all eligible family members for the remainder of the year.
- Amounts over the Maximum Reimbursable Charge do not apply to the Out-of-Pocket Maximum.
- The Out-of-Pocket Maximum is a combined medical and prescription drug Out-of-Pocket Maximum.

Pre-Existing Condition Limitation

<table>
<thead>
<tr>
<th>Pre-Existing Condition Limitation</th>
<th>Not applicable</th>
<th>Not applicable</th>
</tr>
</thead>
</table>
| Pre-Certification, Continued Stay Review, PHS+ Inpatient (required for all inpatient admissions) and PHC Outpatient Pre-Certification (required for selected outpatient procedures and diagnostic testing) | Coordinated by your Physician | • You are responsible for contacting Cigna Healthcare.
  • Subject to a penalty/reduction or denial for non-compliance.
  • $500 penalty applies to Hospital inpatient Charges for failure to contact Cigna Healthcare.
  • Inpatient admission and outpatient procedures/diagnostic testing charges for failure to contact Cigna and Pre-Certify admission.
  • Benefits are denied for any admission, additional days or outpatient procedures/diagnostic testing reviewed by Cigna and not certified. |

Physician Services

<table>
<thead>
<tr>
<th>Physician Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician (PCP) Office Visit</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70%, subject to MRC, after Deductible</td>
</tr>
<tr>
<td>Specialty Care Physician Office Visit</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70%, subject to MRC, after Deductible</td>
</tr>
<tr>
<td>Surgery Performed in Physician Office</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70%, subject to MRC, after Deductible</td>
</tr>
<tr>
<td>Allergy Treatment/Injections</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70%, subject to MRC, after Deductible</td>
</tr>
<tr>
<td>Allergy Serum (dispensed by the Physician in the office)</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70%, subject to MRC, after Deductible</td>
</tr>
<tr>
<td>Growth Hormones (Medically Necessary; administered in Physician office)</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70%, subject to MRC, after Deductible</td>
</tr>
<tr>
<td>Plan Features</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Preventive Care - All Ages</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%, subject to <strong>MRC</strong></td>
</tr>
<tr>
<td></td>
<td>• Includes coverage of additional services, such as urinalysis, EKG and other laboratory tests, supplementing the standard preventive care benefit</td>
<td></td>
</tr>
<tr>
<td>Immunizations - All Ages</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%, subject to <strong>MRC</strong></td>
</tr>
<tr>
<td>Mammogram, PAP, PSA Tests</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%, subject to <strong>MRC</strong></td>
</tr>
<tr>
<td></td>
<td>• Includes the associated preventive outpatient professional services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diagnostic-related services are covered at the same level of benefits as other X-ray and lab services, based on place of service</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Facility</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to <strong>MRC</strong>, after <strong>Deductible</strong></td>
</tr>
<tr>
<td></td>
<td>• Semi-Private Room:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In-Network: Limited to the semi-private negotiated rate</td>
<td></td>
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<tr>
<td></td>
<td>Out-of-Network: Limited to semi-private rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Private Room:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In-Network: Limited to the semi-private negotiated rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: Limited to semi-private rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In-Network: Limited to the negotiated rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: Limited to ICU/CCU daily room rate</td>
<td></td>
</tr>
<tr>
<td>Hospital Physician Visit/Consultation</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to <strong>MRC</strong>, after <strong>Deductible</strong></td>
</tr>
<tr>
<td>Professional Services</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to <strong>MRC</strong>, after <strong>Deductible</strong></td>
</tr>
<tr>
<td></td>
<td>• Includes services performed by surgeons, radiologists, pathologists and anesthesiologists</td>
<td></td>
</tr>
<tr>
<td>Multiple Surgical Reduction</td>
<td>• Multiple surgeries performed during one operating session result in a payment reduction of 50% on the surgery of lesser charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The most expensive procedure is paid as any other surgery</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility Services</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to <strong>MRC</strong>, after <strong>Deductible</strong></td>
</tr>
<tr>
<td></td>
<td>• Includes operating room, recovery room, procedures room, treatment room and observation room</td>
<td></td>
</tr>
<tr>
<td>Professional Services</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to <strong>MRC</strong>, after <strong>Deductible</strong></td>
</tr>
<tr>
<td></td>
<td>• Includes services performed by surgeons, radiologists, pathologists and anesthesiologists</td>
<td></td>
</tr>
<tr>
<td>Short-Term Rehabilitation</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to <strong>MRC</strong>, after <strong>Deductible</strong></td>
</tr>
<tr>
<td>Chiropractic Care Calendar Year Benefit Maximum: 30 visits/days (as deemed Medically Necessary)</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to <strong>MRC</strong>, after <strong>Deductible</strong></td>
</tr>
<tr>
<td><strong>Other Health Care Facilities/Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to <strong>MRC</strong>, after <strong>Deductible</strong></td>
</tr>
<tr>
<td>16 hour maximum per day</td>
<td>• Includes outpatient private duty nursing days when approved as Medically Necessary</td>
<td></td>
</tr>
<tr>
<td>Plan Features</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70%, subject to MRC, after Deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70%, subject to MRC, after Deductible</td>
</tr>
<tr>
<td>Breast Feeding Equipment and Supplies</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%, subject to MRC</td>
</tr>
<tr>
<td></td>
<td>• Limited to the rental of one breast pump per birth as ordered or prescribed by a Physician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Includes related supplies</td>
<td></td>
</tr>
<tr>
<td>External Prosthetic Appliances (EPA)</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70%, subject to MRC, after Deductible</td>
</tr>
<tr>
<td>Routine Foot Disorders</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70%, subject to MRC, after Deductible</td>
</tr>
<tr>
<td>Calendar Year Physician Services Benefit Maximum: $2,500</td>
<td>Includes Charges made for diagnosis and treatment of:</td>
<td></td>
</tr>
<tr>
<td>Lifetime Physician Services Benefit Maximum: $5,000</td>
<td>• Corns, calluses, weak or flat feet</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Any fallen arches, chronic foot strain or instability or imbalance of the feet</td>
<td></td>
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<tr>
<td></td>
<td>• 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)</td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70%, subject to MRC, after Deductible</td>
</tr>
<tr>
<td>Calendar Year Benefit Maximum: 6 visits</td>
<td>Medically Necessary only, limited to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Nausea and vomiting associated with pregnancy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Nausea and vomiting associated with chemotherapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Post-operative nausea and vomiting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Post-operative dental pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The following painful conditions: headache, low back pain, neck pain and knee pain</td>
<td></td>
</tr>
<tr>
<td>Hearing Aid</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 90%, subject to MRC if applicable, after Deductible</td>
</tr>
<tr>
<td>Calendar Year Benefit Maximum: $1,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Benefit Maximum: $10,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biofeedback (Medically Necessary only)</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 70%, subject to MRC, after Deductible</td>
</tr>
<tr>
<td>Oral Surgery - Impacted Wisdom Teeth</td>
<td>Physician Office: Not covered (covered under dental coverage)</td>
<td>Plan pays 70%, subject to MRC, after Deductible</td>
</tr>
<tr>
<td></td>
<td>Inpatient or Outpatient Hospital Facility and Physician Services: Plan pays 90% after Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Includes inpatient facility, outpatient facility and Physician services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Plan coordinates with dental coverage on the extractions</td>
<td></td>
</tr>
<tr>
<td>Wigs</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 90%, subject to MRC if applicable, after Deductible</td>
</tr>
<tr>
<td>Dietary Supplement and Nutritional Formulas</td>
<td>Plan pays 90% after Deductible</td>
<td>Plan pays 90%, subject to MRC if applicable, after Deductible</td>
</tr>
<tr>
<td></td>
<td>• Covered when required for 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 Medically Necessary as the primary source of nutrition</td>
<td></td>
</tr>
<tr>
<td>Plan Features</td>
<td>In-Network</td>
<td>Out-of-Network</td>
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<tr>
<td>---------------</td>
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</tr>
<tr>
<td>Lab and X-Ray</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Emergency Room/Urgent Care Facility: Plan pays 90% after <strong>Deductible</strong> Other Facilities: Plan pays 70%, subject to MRC, after <strong>Deductible</strong></td>
</tr>
<tr>
<td>Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.)</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Emergency Room/Urgent Care Facility: Plan pays 90% after <strong>Deductible</strong> Other Facilities: Plan pays 70%, subject to MRC, after <strong>Deductible</strong></td>
</tr>
<tr>
<td><strong>Emergency and Urgent Care</strong></td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
</tr>
<tr>
<td>Maternity</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to MRC, after <strong>Deductible</strong></td>
</tr>
<tr>
<td>Hospice</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to MRC, after <strong>Deductible</strong></td>
</tr>
<tr>
<td>Abortion (elective and non-elective procedures)</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to MRC, after <strong>Deductible</strong></td>
</tr>
<tr>
<td>Family Planning – Men’s Services</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to MRC, after <strong>Deductible</strong></td>
</tr>
<tr>
<td>Family Planning – Women’s Services</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%, subject to MRC</td>
</tr>
<tr>
<td>Infertility</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to MRC, after <strong>Deductible</strong></td>
</tr>
<tr>
<td><strong>Lifetime Benefit Maximum</strong>: $7,500 (A separate $7,500 lifetime <strong>Benefit Maximum</strong> applies for prescription drugs; see the <strong>Prescription Drug Addendum</strong> for more information)</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to MRC, after <strong>Deductible</strong></td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>LifeSource Facility: Plan pays 100% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to MRC, after <strong>Deductible</strong></td>
</tr>
<tr>
<td><strong>Travel Lifetime Benefit Maximum</strong> (Life-Source Facility Only): $10,000 per transplant</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
</tr>
</tbody>
</table>

- Inpatient Hospital covered under Plan’s inpatient Hospital benefits
- Emergency and Urgent Care: Ambulance services used as non-emergency transportation (e.g., transportation from Hospital home) generally are not covered
- Maternity: Delivery facility (inpatient Hospital, birthing center) covered under Plan’s inpatient Hospital benefits
- Hospice: Includes inpatient Hospital and Other Health Care Facilities as well as Outpatient Services when provided as part of a Hospice Care Program
- Include bereavement counseling services provided as part of Hospice Care Program
- Abortion: Includes surgical services, such as vasectomy (excludes reversals)
- Family Planning – Men’s Services: Includes surgical services, such as tubal ligation (excludes reversals) and contraceptive devices as ordered or prescribed by a Physician
- Infertility: Includes lab and radiology tests, counseling, surgical treatment (including artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.)
- Lifetime Benefit Maximum is combined in- and out-of-network and includes all related services billed with an infertility diagnosis (e.g., lab or X-ray services billed by an independent lab/X-ray facility)
- Includes inpatient facility and professional services
<table>
<thead>
<tr>
<th>Plan Features</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Care</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to <strong>MRC</strong>, after <strong>Deductible</strong></td>
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<tr>
<td></td>
<td>• Includes <strong>Physician</strong> services, inpatient and outpatient facility and professional services</td>
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<tr>
<td></td>
<td>• Limited to <strong>Charges</strong> made for a continuous course of dental treatment started within six months of an <strong>Injury</strong> to sound, natural teeth</td>
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<tr>
<td>Transgender Surgery</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to <strong>MRC</strong>, after <strong>Deductible</strong></td>
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<td></td>
<td>• Must meet certain medically established guidelines for getting surgery</td>
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<tr>
<td>TMJ</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to <strong>MRC</strong>, after <strong>Deductible</strong></td>
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<tr>
<td></td>
<td>• Surgical and non-surgical covered on a case-by-case basis</td>
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<td></td>
<td>• Excludes appliances and orthodontic treatment when <strong>Medically Necessary</strong></td>
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<tr>
<td>Bariatric Surgery</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to <strong>MRC</strong>, after <strong>Deductible</strong></td>
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<td></td>
<td>• Treatment of clinically severe obesity, as defined by the Body Mass Index (BMI)</td>
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<tr>
<td>Mental Health</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to <strong>MRC</strong>, after <strong>Deductible</strong></td>
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<td></td>
<td>• Includes <strong>Inpatient</strong> and <strong>Outpatient Services</strong></td>
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<td></td>
<td>• <strong>Outpatient Services</strong> include individual, group therapy and intensive outpatient treatment</td>
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<td></td>
<td>• Partial hospitalization is covered the same as inpatient <strong>Hospital</strong></td>
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<td></td>
<td>• Residential treatment is covered the same as inpatient if approved through Cigna Behavioral Health Case Management</td>
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<tr>
<td></td>
<td>• Intensive Outpatient Program (IOP) is covered the same as outpatient if approved through Cigna Behavioral Health Case Management</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Plan pays 90% after <strong>Deductible</strong></td>
<td>Plan pays 70%, subject to <strong>MRC</strong>, after <strong>Deductible</strong></td>
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<tr>
<td>Prescription Drugs</td>
<td>Prescription drug benefits are provided by Express Scripts (1-866-219-1933); see the <strong>Prescription Drug Addendum</strong> for more information</td>
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<tr>
<td>Plan Features</td>
<td>In-Network</td>
<td>Out-of-Network</td>
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<tr>
<td><strong>Health and Wellness Programs</strong></td>
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<td></td>
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<tr>
<td>Integrated Personal Health Team – A Care Facility: Pittsburgh Care Center Team Number: 425 Program Name: Live Healthy, Live Well Health Advocate Program Title: Health Advocate</td>
<td>• Your Health First Health and Wellness Coaching • Cigna Well Informed Program • Preference Sensitive Care • Behavioral Health Case Management • 24-hour Health Information Line Outreach • Pre Admission Outreach • Post Discharge Outreach • Inpatient Advocacy • Case Management - Short term and complex • Healthy Steps to Weight Loss Lifestyle Management Program • Quit Today Lifestyle Management Program • Strength and Resilience Lifestyle Management Program • Employee Assistance Program</td>
<td></td>
</tr>
<tr>
<td>Health Pregnancies/Health Babies</td>
<td>• Care management outreach • Maternity case management • Neonatal case management</td>
<td></td>
</tr>
<tr>
<td>MDLIVE Telehealth</td>
<td>Telephone or video consultations; services provided by MDLIVE include the following procedures, covered at 90% after Deductible: • 99441 Telephone consultation (duration up to 10 minutes) • 99442 Telephone consultation (duration up to 11 and 20 minutes) • 99443 Telephone consultation (duration 21 minutes or more) • 99444 Video/Online consultation (any duration)</td>
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</tbody>
</table>

**Additional Benefit Information**

**Integrated Personal Health Team (IPHT) – Live Healthy, Live Well Health Advocate**

The Cigna Integrated Personal Health Team – also referenced as MassMutual Live Healthy, Live Well Health Advocate – 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 Live Healthy, Live Well Health Advocate 9 a.m. – 9 p.m., Monday – Friday, and 9 a.m. – 5 p.m., Saturday.
Case Management

Case management is a service provided through a Review Organization, which assists individuals with certain treatment needs that extend beyond the acute care setting. 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 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 (RNs) 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.

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. Participation in the program is voluntary – no penalty is imposed if you do not want to participate in case management.
- 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.
Your Medical Benefits – The Details

**Covered Services** are expenses incurred by you or your **Dependent** for the charges listed in this section if they are incurred after you or your **Dependent** becomes 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 a **Sickness** or **Injury**, as determined by Cigna. Any applicable amounts you pay and limits are shown in the [Schedule of Benefits](#).

### Preventive Care

Preventive care is subject to the age and/or gender guidelines of the United States Preventive Services Task Force (USPSTF). Your doctor determines the tests that are right for you based on your age, gender and family history. The doctor’s coding of the claim determines if care will be covered as preventive. Visit [http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html](http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html), myCigna.com or call Cigna for the latest list of covered preventive services. This does not guarantee coverage for all preventive services and these services are subject to change.

### 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 an **Other Health Care Facility**, including a **Skilled Nursing Facility**, a rehabilitation **Hospital** or a subacute facility for medical care and treatment; except that for any day of **Other Health Care Facility** confinement, **Covered Services** do not include that portion of charges in excess of any **Other Health Care Facility** limit.
- Charges made for **Emergency Services** and **Urgent Care**.
- Charges made by a **Physician** or **Psychologist** for professional services.
- 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 – 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 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 according to generally accepted medical practices, other medical services, information and counseling on contraception and implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
• Charges made for the following preventive care services (detailed information is available at www.healthcare.gov):
  o Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;
  o Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the covered person involved;
  o For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
  o For women, additional preventive care and screenings not described above, as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
• 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.
• Charges made for the diagnosis and treatment of:
  o Corns, calluses, weak or flat feet;
  o Any fallen arches, chronic foot strain or instability or imbalance of the feet; and
  o Toenails (other than removal of nail matrix or root or services provided in connection with treatment of metabolic or peripheral vascular disease or of a neurological condition).
• Surgical and non-surgical treatment of Temporomandibular Joint (TMJ) dysfunction.
• Charges made for acupuncture, 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), as noted in the Schedule of Benefits. A hearing aid is any device that amplifies sound.
• 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.
• Non-prescription enteral formulas where approved and ordered by a Participating (In-Network) 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 (In-Network) 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, polycose, 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.
• Delivery of health-related services and information via telecommunications technologies, including telephones and “Skype Like” consultations via personal computers or smart phones, when delivered through a contracted telehealth provider.
• Gender reassignment surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

• Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot 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 or 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 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 (In-Network) 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:
  - Require skilled care;
  - Are unable to obtain the required care as an ambulatory outpatient; and
  - Do not require confinement in a Hospital or Other Health Care Facility.
- Home health care services 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 and/or custodial services (e.g., bathing, eating, toileting), home health care services will only be provided for you during times when there is a family member or caregiver 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 Professionals. The services of a home health aide are covered when provided in direct support of skilled health care services provided by Other Health 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 Professionals in providing home health care services are covered. Home health care services do not include services by 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 an Other Health 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 Plan’s short term rehabilitative therapy Benefit Maximums.

Hospice Care Services

- Charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Sickness, for the following Hospice Care Services provided under a Hospice Care Program:
  - By a Hospice Facility for Bed and Board and services and supplies;
  - By a Hospice Facility for services provided on an outpatient basis;
  - By a Physician for professional services;
  - By a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - For pain relief treatment, including drugs, medicines and medical supplies;
  - By an Other Health Care Facility for:
    - Part-time or intermittent nursing care by or under the supervision of a Nurse;
    - Part-time or intermittent services of an Other Health 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.

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MassMutual HDHP-Agent          October 2014          Page 31 of 79
• The following Hospice Care Services are not included as Covered Services:
  o 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;
  o Charges for services for any period when you or your Dependent(s) is not under the care of a Physician;
  o Services or supplies not listed in the Hospice Care Program;
  o Charges for any curative or life-prolonging procedures;
  o Charges for any services to the extent that any other benefits are payable for those expenses under this Plan; and
  o 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 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 Sickness or Injury, are appropriate for use in the home and are not disposable. Such equipment includes, but is not limited to: insulin pumps (which are also covered under the Plan’s prescription drug benefits), 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 Appliances and Devices
• Charges made or ordered by a Physician for the initial purchase and fitting of external Prosthetic Appliances and Devices available only by prescription that are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for external Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

External Prosthetic Appliances and Devices include Prostheses or Prosthetic Appliances and Devices, Orthoses and Orthotic Devices, Braces and Splints.
**Prostheses/Prosthetic Appliances and Devices**

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

- Basic limb Prostheses;
- Terminal devices such as hands or hooks; and
- Speech Prostheses.

**Orthoses and Orthotic Devices**

Orthoses and Orthotic Devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities.

Coverage is provided for custom foot orthoses and other orthoses as follows:

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - Rigid and semirigid custom fabricated orthoses;
  - Semirigid prefabricated and flexible orthoses; and
  - Rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - For persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - When the foot orthosis is an integral part of a leg Brace and is necessary for the proper functioning of the Brace;
  - When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - For persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded Orthoses and Orthotic Devices:

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

**Braces**

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

The following Braces are specifically excluded: Copes scoliosis braces.
Splints

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

Coverage for replacement of external Prosthetic Appliances and Devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external Prosthetic Appliance or Device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - No more than once every 24 months for persons 19 years of age and older; and
  - No more than once every 12 months for persons 18 years of age and under.
- Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external Prosthetic Appliances and Devices:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric Prostheses peripheral nerve stimulators.

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:
  - Reversal of male and female voluntary sterilization;
  - Infertility services when the infertility is caused by or related to voluntary sterilization;
  - Donor charges and services;
  - Cryopreservation of donor sperm and eggs; and
  - 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, pulmonary and cardiac 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:
  o 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;
  o 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;
  o 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
  o 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.

Multiple Outpatient Services provided on the same day constitute one day.

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:
  o Services of a chiropractor that are not within his scope of practice, as defined by state law;
  o Charges for care not provided in an office setting;
  o 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
  o 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:
  o 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.
  o 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.
All transplant services, other than cornea, are covered at 100% when received at Cigna LifeSource Transplant Network® facilities. Cornea transplants are not covered at Cigna LifeSource Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those transplant services, other than Cigna LifeSource Transplant Network® facilities, are payable at the in-network level. Transplant services received at any other facilities, including Non-Participating (Out-of-Network) Providers and Participating (In-Network) Providers not specifically contracted with Cigna for transplant services, are covered at the out-of-network level.

**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 Dependent is the recipient of an organ transplant. No benefits are available when you or your Dependent is a donor.

**Breast Reconstruction and Breast Prostheses**

- Charges made for reconstructive surgery following a mastectomy; 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 placement 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 physical 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 the utilization review Physician.
Mental Health and Substance Abuse Services

Mental health services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to mental health will not be considered to be charges made for treatment of mental health.

Substance abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of substance abuse.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of mental health. Inpatient mental health services include partial hospitalization and mental health residential treatment services.

Partial hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

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.

Mental Health Residential Treatment Center means an institution that:

- Specializes in the treatment of psychological and social disturbances that are the result of mental health conditions;
- Provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians;
- Provides 24-hour care, in which a person lives in an open setting; and
- Is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of providers who are qualified to treat mental health when treatment is provided on an outpatient basis (i.e., while you or your Dependent is not Confined in a Hospital) 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 or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A mental health intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed mental health program. Intensive outpatient therapy programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.
Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient substance abuse services include partial hospitalization sessions and residential treatment services.

Partial hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

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.

Substance abuse Residential Treatment Center means an institution that:

- Specializes in the treatment of psychological and social disturbances that are the result of substance abuse;
- Provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians;
- Provides 24-hour care, in which a person lives in an open setting; and
- Is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance abuse Residential Treatment Center when she/he is a registered bed patient in a Substance abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual or a substance abuse intensive outpatient therapy program.

A substance abuse intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. Intensive outpatient therapy programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from mental health and substance abuse services:

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

The Plan provides coverage for most **Medically Necessary** services. Examples of things the Plan does not cover, unless required by law or covered under the Plan’s prescription drug benefits, include, but are not limited to:

- 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 the treatment and facilities are reasonably available.
- Treatment of a **Sickness** or **Injury** due to war, declared or undeclared, riot or insurrection.
- Charges that 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** services 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 by the utilization review **Physician** to be:
  - Not demonstrated, through existing peer-reviewed, evidence-based scientific literature, to be safe and effective for treating or diagnosing the condition or **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 by the Plan’s clinical trials coverage; or
  - The subject of ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided by the Plan’s clinical trials coverage.
- 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.
- Medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the Body Mass Index (BMI) 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 by this Plan, 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 Care** evaluations.
- Court-ordered treatment or hospitalization, unless the treatment is prescribed by a **Physician** and covered by this Plan.
• 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** services, 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 Treatment** care that 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 by the Plan.

• Private **Hospital** rooms and/or private duty nursing, except as provided by the Plan’s home health services coverage.

• 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 that are not for the specific treatment of **Sickness** 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 refractions, 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 by the Plan.

• 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 the utilization review **Physician’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.

• All nutritional supplements and formulae, except for infant formula needed for the treatment of inborn errors of metabolism, unless specifically provided as covered by the Plan.

• Services for or in connection with an **Injury** or **Sickness** arising out of, or in the course of, any employment for wage or profit.
• Email consultations.
• Delivery of health-related services and information via telecommunications technologies, including telephones and “Skype Like” consultations via personal computers or smart phones, unless delivered through a contracted telehealth provider.
• Massage therapy.
• Expenses for supplies, care, treatment or surgery that are not Medically Necessary.
• To the extent that you or any of your Dependents are in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
• To the extent that payment is unlawful where the person resides when the expenses are incurred.
• Charges made by a Hospital, owned or operated by or that provides care or performs services for, the United States Government, if the charges are directly related to a military service-connected Injury or Sickness.
• Charges that would not have been made if the person had no insurance.
• Expenses to the extent they are more than the Maximum Reimbursable Charge.
• To the extent of the exclusions imposed by any Plan certification requirement.
• Expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergency care while temporarily traveling.
Claiming Benefits

Filing Claims

When you or your Dependent(s) seeks care from a Participating (In-Network) 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 Dependent(s) seeks care from a Non-Participating (Out-of-Network) 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 results 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.

Claim Reminders

• Be sure to use your Member ID and account number when you file Cigna’s claim forms or when you call Cigna’s claim office. Your Member ID is the ID number shown on your benefit ID card.
• Prompt filing of any required claim results in faster payment of your claim.

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 possible, get a 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.

Timely Filing of Out-of-Network Claims

For out-of-network benefits (for example, for a medical emergency), Cigna considers coverage claims when proof of loss (a claim) is submitted within 365 days after services are provided. If services are provided on consecutive days, such as for a Hospital Confinement, the time limit is counted from the last date of service. If claims are not submitted within 365 days for out-of-network benefits, the claim will not be considered valid and will be denied.
Benefit Determinations

Note: Cigna’s claims and appeals procedures comply with federal law.

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 claim determination.” You or your authorized representative (typically, your health care provider) must request Pre-Authorization 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 Claim Determinations

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

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, Cigna will make the pre-service determination on an expedited basis. Cigna’s Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request of what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within three days by written or electronic notification.

If you or your representative does not follow the procedures for requesting a required pre-service determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing 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 Claim 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 coverage determination at least 24 hours before the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.
Post-Service Claim Determinations

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

Payment of Benefits

All medical benefits are payable to you. However, medical benefits are assignable to your provider. When you assign benefits to a provider, you assign the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting payment on the charge, it is the provider’s responsibility to reimburse the patient. Because of Cigna’s contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any covered expenses from a Non-Participating (Out-of-Network) Provider even if benefits have been assigned. When benefits are paid to you or your Dependent(s), you or your Dependent(s) is responsible for reimbursing the provider.

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

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

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

Calculation of Covered Expenses

Cigna, at its discretion, calculates covered expenses following evaluation and validation of all provider billings in accordance with the methodologies:

• In the most recent edition of the Current Procedural Terminology; or
• As reported by generally recognized professionals or publications.

Recovery of Overpayment

When an overpayment is made by Cigna, Cigna has the right at any time to:

• Recover that overpayment from the person to whom, or on whose behalf, it was made; or
• Offset the amount of that overpayment from a future claim payment.
Adverse Benefit Determination

An adverse benefit determination (e.g., a claim denial) is any denial, reduction or termination of a benefit or a failure to provide or make a payment in whole or in part for a benefit. An adverse benefit determination also includes a rescission (or cancellation) of coverage on a retroactive basis.

If your claim is denied, in whole or in part, Cigna will provide you with a written or electronic notice of the reason for the denial. The notice will include:

- Information sufficient to identify the claim (including, upon request, the diagnosis and treatment codes and their meanings);
- 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 the material or information is necessary;
- A description of the Plan’s internal appeals and external review procedures and the time limits applicable, including a statement of your rights to bring a civil action under ERISA Section 502(a) following an adverse benefit determination or appeal (if applicable);
- Upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit;
- In the case of a claim involving Urgent Care, a description of the expedited review process applicable to that claim; and
- Contact information for any applicable office of health insurance consumer assistance or ombudsman that will assist you with internal claims and appeals and the external review process.
Appeal Procedures

For this section, any reference to “you” or “your” 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 Customer Service

Cigna Customer Service personnel are available to listen and help. If you have a concern regarding a person, service, quality of care, contractual benefits or rescission of coverage, 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 Customer Service 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 coverage decision, you may start the appeal process.

Exception: Send appeals related to Plan eligibility matters (including loss or denial of coverage) within 180 days of loss or denial of coverage to the Claims Review Committee. If your appeal to the Claims Review Committee is denied, you may initiate a second-level appeal with the Plan Administrative Committee. Decisions made by the Plan Administrative Committee are final. The Claims Review and Plan Administrative Committees may be contacted at:

MassMutual Benefits
1295 State Street, F105
Springfield, MA 01111-0001

Appeal Procedure

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 or address on your Cigna ID card, explanation of benefits or claim form.

As part of your appeal, you can submit written comments, documents, records or other information relating to your claim. In addition, you will be provided, upon written request and free of charge, reasonable access to (and copies of) all documents, records and other information relevant to your claim. The review will take into account all comments, documents, records and other information submitted relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination. However, no consideration will be given to the initial denial of your claim during the review of the claim or appeal. In addition, someone who was not involved in the initial decision and who is not a subordinate of any individual who was involved in the initial decision will conduct the review.

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Contact Cigna by phone or mail at the toll-free number or address on your Cigna ID card, explanation of benefits or claim form. If Cigna does not strictly adhere to all requirements of the internal claims and appeals processes, you may initiate an external independent review (if your claim involves medical judgment or a rescission of coverage) and/or pursue any available remedies under applicable law.
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.

If any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with your appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of its decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of its decision so that you will have an opportunity to respond. Cigna will also provide you with the identity of any medical experts involved in the initial decision.

Cigna will respond in writing with a decision within:
- 30 calendar days after receipt of an appeal for a required pre-service or concurrent care coverage determination; or
- 60 calendar days after receipt of an appeal for a post-service coverage determination.

You may request that the appeal process be expedited if:
- The time frames under this process would seriously jeopardize your life, health or ability to regain maximum 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 Pre-Authorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on this process’ timeframes, you may also ask for an expedited external independent review at the same time, if the time to complete an expedited appeal would be detrimental to your medical condition.

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

**Adverse Benefit Determination Notice on Appeal**

For an adverse benefit determination on appeal, Cigna will provide a written or electronic notice that will include:
- Information sufficient to identify the claim (including, upon request, the diagnosis and treatment codes and their meanings);
- The specific reason or reasons for the adverse determination (including the denial code and its corresponding meaning and a description of the Plan’s standard, if any, applied in denying the claim);
- 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 the 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 (as defined below);
- A description of any additional voluntary appeal procedures offered by the Plan, including the opportunity for you to request an external review by an independent Review Organization and your right to bring a civil action under ERISA Section 502(a);
- Upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination on your appeal;
• 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
• Contact information for any applicable office of health insurance consumer assistance or ombudsman available to assist you in the appeal process.

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

**External Review Procedure**

If you are not fully satisfied with the decision of Cigna’s internal appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent **Review Organization** (IRO). The IRO is composed of persons who are not employed by Cigna or any of its affiliates. A decision to request an external review to an IRO will not affect your rights to any other benefits under the Plan.

There is no charge for you to initiate the external review process. Cigna and the Plan will abide by the decision of the IRO.

To request a review, you must notify the Appeals Coordinator, as identified in your adverse determination notice, within four months of your receipt of Cigna’s appeal review denial. Within five business days after receipt of the request, Cigna will complete a preliminary review to determine if your claim is eligible for external review, and provide you with notice of its decision within one business day.

If your request is complete but not eligible for review, the notice will explain the reason(s) for ineligibility and provide contact information for the Employee Benefits Security Administration.

If your request is incomplete, the notice will describe the information needed to complete the request. You will have until the later of the end of the four-month period you had to file a request for external review or the 48-hour period following receipt of the notice to provide all of the needed information.

If your claim is eligible for external review, Cigna will forward your complete file to a randomly selected IRO. If there is any information (or evidence) you want to submit in support of the request for an external review that was not previously provided, you may include this information with your request for an external review. The IRO will render an opinion within 30 days. All decisions of the Independent **Review Organization** are final.

** Expedited External Review Procedure**

In certain circumstances, you may receive an expedited external review. In this case, you do not have to exhaust the internal appeals process before filing a request for an external review. You may request an expedited external review for **Urgent Care** claims at the same time you request an appeal of the denied claim. In addition, you may request an expedited external review if your claim is a non-**Urgent Care** claim and a delay would be detrimental to your medical condition, as determined by Cigna’s **Physician** reviewer or if your appeal concerns an admission, availability of care, continued stay or health care item or service for which you received **Emergency Services**, but you have not been discharged from a facility. The IRO will immediately conduct a preliminary review to determine if your claim is eligible for external review. You will be notified of the final determination on your claim as expeditiously as your medical condition or circumstances require, but in no event later than 72 hours after the IRO receives the request for an expedited external review. If you receive a verbal notice, a written notice will follow within 48 hours.
**Relevant Information**

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

- Was relied on in making the benefit determination;
- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether the document, record or other information was relied on in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or
- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit or the claimant’s diagnosis, without regard to whether the advice or statement was relied on 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 appeal process. In most instances, you may not initiate a legal action against the Plan until you have completed the appeal process. If your appeal is expedited, there is no need to complete the process before bringing legal action. No legal action may begin more than one year after the date you have exhausted the Plan’s claim and appeal process. No legal action may begin more than one year after the date you have exhausted the Plan’s claim and appeal process.
About Your Coverage

If You Leave the Company

Your coverage ends on the last day of the month in which your contract terminates. At that time, you may be eligible for COBRA continuation coverage; refer to the COBRA section for more information.

If You Have Benefits Debt

If you are an agent who has benefits debt, coverage will be terminated upon attainment of the sixth cycle of benefits debt. Once coverage is terminated due to debt, it cannot be reinstated until the beginning of the next Plan Year after the debt has been repaid, provided your contract remains active.

Example: If your benefits are cancelled September 9 due to being six cycles in benefit debt and you repay your debt on November 20, you will be allowed back in the Plan at the start of the next Plan Year (January 1). If you missed the Annual Benefits Enrollment period, contact Producer Services & Operations so they can open your record and you can enroll.

If you do not pay your debt back and enroll by the last day of the Plan Year, you cannot come back into the Plan for another full year. If your contract is terminated and you are later recontracted, benefits cannot be reinstated until the beginning of the Plan Year after your debt has been paid in full.

If You Become Disabled

If you are receiving Long-Term Disability (LTD) benefits under the MassMutual Agent’s Welfare Benefits Plan LTD option, you may be eligible to continue medical coverage. Refer to the Contract & Benefit Production Requirement Exceptions For Disabled Agents (Company Memo 2013-021 or its successor) for details on benefits while on disability. You can access this Memo on FieldNet by using the search function (type 2013-021 in the Forms & Docs search field). Also, refer to the applicable Minimum Production Requirements for the Career Agent Contract and Qualification for Subsidized Benefits Company Memo (Memo 2013-018 or its successor).

If You Retire

Upon retirement, you may be eligible to continue your medical coverage if you meet certain age and service requirements. Not everyone is eligible for retiree medical and a subsidy for retiree medical. As you approach your targeted retirement date, if eligible for retiree medical coverage, you may want to request a retiree medical cost quote from Producer Services & Operations.

If You Die

If you die while you are an active agent covered by the Plan, your surviving Dependents who were covered 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. Additional provisions may apply for certain retirement eligible agents. For more information, contact Producer Services & Operations.
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. 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

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 month in which your contract terminates;
- The date you or your Dependent(s) commits a fraudulent act under this Plan, including, but not limited to:
  o Submitting a fraudulent claim;
  o Enrolling an ineligible dependent;
  o Misrepresenting your tobacco use status; or
- Your death.

Note: The above bullets also apply to Spouses and Dependents who are covered as survivors.

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 Producer Services & Operations in writing within 30 days that 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;
- The date the child becomes a member in the armed services; 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 your disabled child older than age 25 is no longer incapable of self-care; or
- For Domestic Partner children, the date your domestic partnership ends.
You must notify Producer Services & Operations in writing within 30 days of any of the above events that would cause your child to lose coverage.

If you commit a fraudulent act or intentionally misrepresent a material fact, such as enrolling an individual who you know is not eligible to participate in the Plan or filing a claim that contains any false or misleading information, your and your Dependents’ coverage may be rescinded (that is, cancelled or discontinued) with retroactive effect and you may be required to reimburse the Plan for payments made from the Plan. If this occurs, notice will be provided to you at least 30 calendar days before the date coverage is rescinded.

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. Note: After December 31, 2014, certificates of creditable coverage will no longer be required under law, and will therefore no longer be necessary or available.
The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, allows you and your Dependents to temporarily continue coverage 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 career contract terminates for any reason, except gross misconduct or due to benefits debt (termination of coverage due to benefits debt is not a COBRA qualifying event).

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

- Your death;
- Your divorce, marriage annulment or legal separation (you must send Producer Services & Operations a copy of your divorce decree or other form of documentation proving you are divorced, your marriage is annulled or you are legally separated within 60 days of the date of your divorce, annulment or legal separation);
- Your child becoming ineligible for coverage (you must notify Producer Services & Operations within 60 days of the date your child becomes ineligible);
- Your Domestic Partner and/or your Domestic Partner’s child(ren) becoming ineligible for coverage (COBRA-like coverage may be available); or
- Your enrollment in Medicare (Part A, Part B or both).

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

If you elect COBRA coverage and the Social Security Administration determines that you or your Dependent(s) was permanently and totally disabled at any time within the first 60 days 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) for the first 18 months, and then 150% for the remaining 11 months.

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>
<tbody>
<tr>
<td>18 Months</td>
<td>• Your career contract terminates</td>
</tr>
<tr>
<td></td>
<td>• You retire</td>
</tr>
<tr>
<td></td>
<td>• The Company declares bankruptcy</td>
</tr>
<tr>
<td>29 Months (18 months plus 11 months, see below)</td>
<td>• You are disabled as determined by the Social Security Administration within the first 60 days of continuation coverage</td>
</tr>
<tr>
<td>36 Months (for Dependents)</td>
<td>• You die</td>
</tr>
<tr>
<td></td>
<td>• You divorce, have your marriage annulled or legally separate</td>
</tr>
<tr>
<td></td>
<td>• Your child(ren) becomes ineligible</td>
</tr>
<tr>
<td></td>
<td>• You enroll in Medicare (Part A, Part B or both)</td>
</tr>
</tbody>
</table>
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 myBenefits.

**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 **Dependent(s)** becomes eligible. COBRA notification is sent by first-class mail within 14 calendar days after Producer Services & Operations receives notice of a qualifying event. In the case of a divorce, annulment, legal separation or the ineligibility of a child, you or your **Dependent(s)** must notify Producer Services & Operations within 60 days of the later of the date:

- Of the COBRA qualifying event;
- Of the loss of coverage due to the qualifying event; or
- On which you are informed of your obligation to provide notice and the procedures for doing so.

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 elect coverage 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 **Dependent(s)** was 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 **Dependants** can qualify for an additional 11 months of coverage. If the Social Security Administration determines that you or your **Dependent** is no longer disabled, you must notify the COBRA TPA within 30 days after the determination.

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 in the Continuation of Coverage section);
- 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 (**Dependants** may be eligible for continued COBRA coverage).

COBRA coverage may also end for any reason the Plan would terminate coverage of a **Participant** or beneficiary not receiving COBRA coverage, such as fraud.
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. TDD/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 Producer Services & Operations for additional information. Please be advised that you must contact Producer Services & Operations promptly after qualifying for assistance under TAA or you may lose your special COBRA rights.

Conversion Rights

If you or your Dependent(s) does 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 from Benefit Concepts confirming your participation in the Plan when your coverage ends. Certificates also can be obtained upon request.
Coordination of Benefits

If you or your Dependent(s) has 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.

This section, which applies if you or any one of your Dependents is covered under more than one Plan, describes how the Plan determines how benefits payable from all plans will be coordinated. You should file all claims with each Plan. Coverage under this Plan plus another Plan (as defined below) will not guarantee 100% reimbursement.

Definitions

The following terms and their definitions relate to this section only.

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured that:
  - Cannot be purchased by the general public; or
  - Is not individually underwritten (including closed panel coverage).
- Coverage under Medicare and other governmental benefits as permitted by law, except Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each plan or part of a plan that has the right to coordinate benefits will be considered a separate plan.

Closed Panel Plan

A plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in emergency or if referred by a provider within the panel.

Primary Plan

The plan that determines and provides or pays benefits without taking into consideration the existence of any other plan.

Secondary Plan

A plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the reasonable cash value of any services provided.

Reasonable Cash Value

An amount that a duly licensed provider of health care services usually charges patients within the range of fees usually charged for the same service if rendered under similar or comparable circumstances by other health care providers located within the immediate geographic area where the health care service was delivered.
**Order of Benefit Determination Rules**

When you or your **Dependent(s)** is 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 that does not have a coordination of benefits rule consistent with this section will always be the **Primary Plan**. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is used:

<table>
<thead>
<tr>
<th>If . . .</th>
<th>Then . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>A plan covers a person as an enrollee or an agent</td>
<td>• That plan will be the <strong>Primary Plan</strong> and the plan that covers that person as a <strong>Dependent</strong> will be the <strong>Secondary Plan</strong>.</td>
</tr>
<tr>
<td>A <strong>Dependent</strong> child’s parents are not divorced or legally separated</td>
<td>• The <strong>Primary Plan</strong> will be the plan that covers the parent whose birthday falls first in the calendar year.</td>
</tr>
<tr>
<td>A <strong>Dependent</strong> child’s parents are divorced or separated</td>
<td>Benefits for the <strong>Dependent</strong> will be determined in the following order:</td>
</tr>
<tr>
<td></td>
<td>• First, if a court decree states that one parent is responsible for the child’s health care expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;</td>
</tr>
<tr>
<td></td>
<td>• Then, the plan of the parent with custody of the child;</td>
</tr>
<tr>
<td></td>
<td>• Then, the plan of the spouse of the parent with custody of the child;</td>
</tr>
<tr>
<td></td>
<td>• Then, the plan of the parent without custody of the child; and</td>
</tr>
<tr>
<td></td>
<td>• Finally, the plan of the spouse of the noncustodial parent of the child.</td>
</tr>
<tr>
<td>A plan covers you as an active agent (or as that agent’s <strong>Dependent</strong>)</td>
<td>• That plan will be the <strong>Primary Plan</strong> and the plan that covers you as laid-off or retired agent (or as that agent’s <strong>Dependent</strong>) will be the <strong>Secondary Plan</strong>.</td>
</tr>
<tr>
<td></td>
<td>• If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this rule will not apply.</td>
</tr>
<tr>
<td>A plan covers you under a right of continuation that is provided by federal or state law</td>
<td>• That plan will be the <strong>Secondary Plan</strong> and the plan that covers you as an active agent or retiree (or as that agent’s <strong>Dependent</strong>) will be the <strong>Primary Plan</strong>.</td>
</tr>
<tr>
<td></td>
<td>• If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this rule will not apply.</td>
</tr>
<tr>
<td>One of the plans that covers you is issued outside of the state whose laws govern this Plan, and determines the order of benefits based upon the gender of a parent, and as a result, the plans do not agree on the order of benefit determination</td>
<td>• The plan with the gender rules will determine the order of benefits.</td>
</tr>
<tr>
<td>If none of the above rules determines the order of benefits</td>
<td>• The plan that has covered you for the longer period will be primary.</td>
</tr>
</tbody>
</table>

When coordinating benefits with Medicare, this Plan will be the **Secondary Plan** and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above will be used to determine how benefits will be coordinated. This Plan will be primary when required by Medicare law.
**Effect on Plan Benefits**

If this Plan is the **Secondary Plan**, the benefits that would be payable under this Plan in the absence of coordination will be reduced by the benefits payable by all other plans for the expense covered by this Plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an **Expense Incurred** and a benefit payable.

**Recovery of Excess Benefits**

If this Plan pays charges for services and supplies that should have been paid by the **Primary Plan**, the Plan has the right to recover the payments.

The Plan has sole discretion to seek recovery from any person to, or for whom, or with respect to whom, the services were provided or the payments were made by any insurance company, health care plan, or other organization. If requested, you will execute and deliver the instruments and documents determined necessary to secure the Plan’s right of recovery.

**Right to Receive and Release Information**

The Plan, without consent or notice to you, may obtain information from and release information to any other plan with respect to you to coordinate your benefits according to this section. You must provide any requested information to coordinate your benefits according to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the “other coverage” information (including an explanation of benefits paid under the **Primary Plan**) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

**Medicare Eligible**

The Plan will pay as the **Secondary Plan** as permitted by the Social Security Act of 1965, as amended, for:

- A former agent who is eligible for Medicare and whose insurance is continued for any reason as provided in this Plan;
- A former agent’s **Dependent** who is eligible for Medicare and whose insurance is continued for any reason as provided in this Plan;
- An agent whose employer and each other employer participating in the employer’s plan have fewer than 100 employees and that agent is eligible for Medicare due to disability;
- A **Dependent** of an agent whose employer and each other employer participating in the employer’s plan have fewer than 100 employees and that **Dependent** is eligible for Medicare due to disability;
- An agent or **Dependent** of an agent whose employer has fewer than 20 employees and that agent or **Dependent** is eligible for Medicare due to age;
- An agent, retired agent, agent’s **Dependent** or retired agent’s **Dependent** who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.
The Plan assumes the amount payable under:

- Part A of Medicare for a person who is eligible for Part A (without premium payment) is the amount he or she would have received (even if he or she did not apply).
- Part B of Medicare for a person who is entitled to be enrolled in Part B is the amount he or she would receive (even if he or she is not enrolled).
- Part B of Medicare for a person who has entered into a private contract with a provider is the amount he or she would receive in the absence of the private contract.

You are considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for you.

This reduction will not apply to any agent or any former agent and his/her Dependent unless listed above.

**Domestic Partners**

Under federal law, Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan. Therefore, Medicare is generally the Primary Plan for a person covered as a Domestic Partner.

**Expenses for Which a Third Party May Be Responsible**

This Plan does not cover:

- **Expenses Incurred** by you or your Dependent (referred to as “you” throughout these sections) for which another party may be responsible as a result of having caused or contributed to an Illness or Injury.
- **Expenses Incurred** by you to the extent any payment is received either directly or indirectly from a third party lawsuit or due to a settlement, judgment, or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers’ compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

**Subrogation and Right of Reimbursement**

If you incur a covered expense for which, in the opinion of the Plan or its claims administrator, another party may be responsible or for which you may receive payment as described above:

- **Subrogation:** The Plan will, to the extent permitted by law, be subrogated to all rights, claims or interests that you may have against the party and will automatically have a lien upon the proceeds of any recovery by you from the party to the extent of any benefits paid under the Plan. You or your representative will execute the documents as may be required to secure the Plan’s subrogation rights.
- **Right of Reimbursement:** The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted above, but only to the extent of the benefits provided by the Plan.
Lien of the Plan

By accepting benefits under this Plan, you:

• Grant a lien and assign to the Plan an amount equal to the benefits paid under the Plan against any recovery made by you or on your behalf that is binding on any attorney or other party who represents you whether or not your agent, any insurance company, or other financially responsible party against whom you may have a claim provided the attorney, insurance carrier, or other party has been notified by the Plan or its agents;

• Agree that this lien will constitute a charge against the proceeds of any recovery and the Plan will be entitled to assert a security interest thereon; and

• Agree to hold the proceeds of any recovery in trust for the benefit of the Plan to the extent of any payment made by the Plan.

Additional Terms

No adult may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of the adult without the prior express written consent of the Plan. The Plan’s right to recover will apply to decedents’, minors’, and incompetent or disabled persons’ settlements or recoveries.

You will not make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.

The Plan’s right of recovery will be a prior lien against any proceeds you recover. This right of recovery will not be defeated nor reduced by the application of any so-called “made-whole doctrine,” “Rimes doctrine,” or any other doctrine purporting to defeat the Plan’s recovery rights by allocating proceeds exclusively to non-medical expense damages.

You will not incur any expenses on behalf of the Plan in pursuit of the Plan’s rights; no court costs, attorneys’ fees or other representatives’ fees may be deducted from the Plan’s recovery without the prior express written consent of the Plan. This right will not be defeated by any so-called “fund doctrine,” “common fund doctrine,” or “attorney’s fund doctrine.”

The Plan will recover the full amount of benefits provided without regard to any claim of fault on your part, whether under comparative negligence or otherwise.

If you do not, or refuse to, honor your obligations, then the Plan will be entitled to recover any costs incurred in enforcing these terms, including, but not limited to, attorney’s fees, litigation, court costs, and other expenses. The Plan will also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits until you have fully complied with these reimbursement obligations, regardless of how those future medical benefits are incurred.

Any reference to state law in any other provision of this Plan will not be applicable to this provision. By acceptance of benefits under the Plan, you agree that a breach would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan will be entitled to invoke equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, and injunctive relief.
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 has no liability for benefits described in this document.
- 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 (In-Network) 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 (In-Network) Providers, nor is the claims administrator responsible or liable for the treatment, services or supplies provided by Participating (In-Network) 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 network and who is available to accept you or your eligible Dependents. For information on how to select a Primary Care Provider, and for a list of the participating Primary Care Providers, contact 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.

Notice of Provider Directory/Networks

You may also access a list of providers who participate in the network by visiting www.Cigna.com, www.myCigna.com, or by calling the toll-free telephone number on your ID card. The Participating (In-Network) Provider network consists of a group of local medical practitioners, including Hospitals, of varied specialties as well as general practice, who are employed by or contracted with Cigna.
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 Cigna will follow this decision. You must enroll or be enrolled in coverage before you can enroll any child(ren) according to a QMCSO.

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

You or your Dependent(s) can obtain procedures for QMCSO determinations at no charge by contacting Producer Services & Operations.

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 myBenefits and FieldNet (My Practice/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 or concerns or if you want to request 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 Mid-Year Qualifying Event (i.e., marriage, divorce, loss of coverage, death of Spouse, birth, adoption, etc.). Please contact Producer Services & Operations for more information.

The Commonwealth of Massachusetts requires the Company to report Massachusetts-based agents 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. (However, as of July 1, 2013, you are no longer required to fill out a HIRD form.)
For Massachusetts residents, you may be eligible for coverage through The Health Connector if:

- You 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 Dependent(s) does 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](http://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 Agents’ Welfare Benefits Plan, 506

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 Agent Health Benefit Trust (Trust) and Trust assets are used to fund Plan benefits and pay claims and administrative fees. 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. 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. 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.
ERISA Rights

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:
  o You lose Plan coverage;
  o You become entitled to elect COBRA coverage; or
  o 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. **Note:** After December 31, 2014, certificates of creditable coverage will no longer be required under law, and will therefore no longer be provided.

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 Maximum Reimbursable Charge (MRC), any amount in excess of the highest MRC is not an Allowable Expense.
- If you are covered by one plan that provides services or supplies on the basis of the Maximum Reimbursable Charge 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 Participating (In-Network) 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 designated by the Company when you may make changes to your benefit elections. Changes are effective the following January 1.

Bed and Board
Charges by a Hospital for room, meals and all general services and activities needed for the care of a registered bed patient.

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.

Brace
An orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.
Charges

The actual billed charges, except when the provider has contracted directly or indirectly with Cigna for a different amount.

Chiropractic Care

The conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment provided to specific joints to restore motion, reduce pain and improve function.

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/or the Plan pays 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 Care includes, but is not limited to:

- Services related to watching or protecting a person;
- Services 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
- Services 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:

- Current Spouse (same-sex or opposite-sex, not including an ex-Spouse) or Domestic Partner, as defined by the Plan; and
- Eligible Dependent Child(ren), as defined by the Plan.

MassMutual reserves the right to verify a Dependent’s eligibility status for Plan coverage at any time, or from time to time, by requiring you to provide supporting documentation. Failure to provide supporting documentation may result in loss of coverage.
**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 in such a way that would make a marriage illegal in your state of residence;
- 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;
- Your legally adopted child;
- A child 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.

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.

**Emergency Medical Condition**

A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that a **Prudent Layperson**, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

**Emergency Services**

For an **Emergency Medical Condition**, a medical screening examination that is within the capability of the emergency department of a **Hospital**, including ancillary services routinely available to the emergency department to evaluate the **Emergency Medical Condition** and that further medical examination and treatment, to the extent within the capabilities of the staff and facilities available at the **Hospital**, to **Stabilize** the patient.
Essential Health Benefits

To the extent covered under the Plan, expenses incurred for Covered Services, in at least the following categories: ambulatory patient services, Emergency Services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Expense Incurred

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

Free-Standing Surgical Facility

An institution that:

- Has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- Maintains at least two operating rooms and one recovery room;
- Maintains diagnostic laboratory and X-ray facilities;
- Has equipment for Emergency Services;
- Has a blood supply;
- Maintains medical records;
- Has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- Is licensed according to the laws of the appropriate legally authorized agency.

Hospice Care Program

A program that:

- Is coordinated and interdisciplinary to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- Provides palliative and supportive medical, nursing and other health services through home or Inpatient Care during the Sickness; and
- Is for a person who has a Terminal Illness and for his or her family.

Hospice Care Services

Any services provided under a Hospice Care Program by:

- A Hospital;
- A Skilled Nursing Facility or a similar institution;
- A home health care agency;
- A Hospice Facility; or
- Any other licensed facility or agency.
Hospice Facility

An institution or part of an institution that:

- Primarily provides care for Terminally Ill patients;
- Is accredited by the National Hospice Organization;
- Meets standards established by Cigna; and
- Fulfills any licensing requirements of the state or locality in which it operates.

Hospital

An institution:

- Licensed as a hospital that:
  - Maintains, on the premises, all facilities necessary for medical and surgical treatment;
  - Provides treatment on an inpatient basis, for compensation, under the supervision of Physicians; and
  - Provides 24-hour service by graduate registered nurses;
- Qualified as a hospital, psychiatric hospital or tuberculosis hospital and a provider of services under Medicare, if the institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- Specializing in treatment of mental health and substance abuse or other related Sickness, provides residential treatment programs and is licensed according to the laws of the appropriate legally authorized agency.

A Hospital does not include an institution that is primarily a place for rest, a place for the aged or a nursing home.

Hospital Confinement or Confined in a Hospital

You are considered Confined in a Hospital if you are:

- A registered bed patient in a Hospital on a Physician’s recommendation;
- Receiving treatment for mental health and substance abuse services in a partial hospitalization program; or
- Receiving treatment for mental health and substance abuse services in a Mental Health or Substance Abuse Residential Treatment Center.

Injury

An accidental bodily injury.

Inpatient Care or Inpatient Services

Services you receive while admitted to the Hospital and directed to stay for at least 24 hours.

Maintenance Treatment

Treatment provided to keep or maintain a patient’s current status.

Maximum Reimbursable Charge (MRC)

The charge determined based on the lesser of:

- The provider’s normal charge for a similar service or supply; or
- A percentage of a fee schedule developed by Cigna that is based on a methodology similar to a methodology used by Medicare to determine the allowable fee for the same or similar services within the geographic area.
In some cases, a Medicare-based schedule is not used and the MRC is determined based on the lesser of the:

- Provider’s normal charge for a similar service or supply; or
- Amount charged by providers for that service or supply in the geographic area where the service or supply is received.

MRC is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines MRC is available from Cigna upon request.

**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 a Sickness, 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 Sickness, 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 Sickness, 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.

**Mental Health Residential Treatment Center**

An institution that:

- Specializes in the treatment of psychological and social disturbances that are due to a mental health condition;
- Provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians;
- Provides 24-hour care in which a person lives in an open setting; and
- Is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when he/she is a registered bed patient in a Mental Health Residential Treatment Center the recommendation of a Physician.

**Mid-Year Qualifying Event**

Any change to your medical coverage due to a Mid-Year Qualifying Event must be consistent with and on account of the Mid-Year Qualifying Event. If you have a Mid-Year Qualifying Event, you can change your existing level of medical coverage (e.g., change from individual to family coverage), enroll in coverage for the first time if you previously waived coverage or drop coverage. You must make any changes and provide documentation within 30 days of your Mid-Year Qualifying Event (90 days for birth, adoption or placement for adoption). For more information, see the Mid-Year Qualifying Event section.
Necessary Services and Supplies

Any charges:
- By a Hospital for medical services and supplies (except charges for Bed and Board) actually used during Hospital Confinement;
- By whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- By whomever made, for the administration of anesthetics during Hospital Confinement.

Necessary Services and Supplies do not include any charges for special nursing, dental or medical fees.

Non-Participating Provider or Out-of-Network Provider

A Hospital, Physician or any Other Health Professional or entity that does not have a direct or indirect contractual arrangement with the carrier to provide Covered Services at negotiated rates.

Nurse

A graduate Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN).

Order of Benefit Determination Rules

When you or your Dependent(s) is 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.

Other Health Care Facility

A facility other than a Hospital or Hospice Facility, such as, but not limited to, licensed Skilled Nursing Facilities, rehabilitation Hospitals and subacute facilities.

Other Health Professional

An individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies, including, but not limited to, physical therapists, registered nurses and licensed practical nurses.

Orthoses and Orthotic Devices

Orthopedic appliances or apparatuses used to support, align, prevent or correct deformities.

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 or In-Network Provider

A Hospital, Physician or any Other Health Professional or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services at negotiated rates for Members covered under this Plan.

Patient Protection and Affordable Care Act (PPACA)

The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Physician

A licensed medical practitioner practicing within the scope of his/her license and licensed to prescribe and administer drugs or perform surgery. This also includes any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if the practitioner is operating within the scope of his/her license and performing a service for which benefits are provided under this Plan when performed by the Physician.

Plan Year

The Plan Year is the 12-month period from January 1 to December 31.

Pre-Authorization, Pre-Authorized, Pre-Certification or Pre-Certify

The approval that a Participating (In-Network) Provider must receive from the Review Organization before providing services for certain services and benefits to be covered.

Preventive Treatment

Treatment provided to prevent disease or its recurrence. The doctor’s coding of the claim determines if care is covered as preventive.

Primary Care Physician (PCP)

A Physician who qualifies as a Participating (In-Network) Provider in general practice, internal medicine, family practice or pediatrics and who is selected by you, as authorized by Cigna, to provide or arrange for medical care for you or any of your covered Dependents.

Primary Plan

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

Prostheses or Prosthetic Appliances and Devices

Fabricated replacements for missing body parts. Prostheses or Prosthetic Appliances and Devices include, but are not limited to:

- Basic limb Prostheses;
- Terminal devices, such as hands or hooks; and
- Speech Prostheses.
Psychologist

A person licensed or certified as a clinical Psychologist. Where no licensure or certification exists, a Psychologist is a person considered qualified as a clinical Psychologist by a recognized psychological association. This also includes any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if the practitioner is:
- Operating within the scope of his/her license; and
- Performing a service for which benefits are provided under this Plan when performed by a Psychologist.

Qualified Medical Child Support Order (QMCSO)

A judgment, decree or order that meets all of the following criteria:
- Is issued by a court relating 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; and
- Includes certain information relating to the Participant and alternate recipient.

Review Organization

An affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians, which may include Physicians, registered nurses, licensed mental health and substance abuse professionals and other trained staff members who perform utilization review services.

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.

Sickness or Illness

A physical or mental illness, including pregnancy. Expenses Incurred for routine Hospital and pediatric care of a newborn child before discharge from the Hospital nursery are considered to be incurred due to Sickness.

Skilled Nursing Facility

A licensed institution (other than a Hospital) that specializes in physical rehabilitation on an inpatient basis or skilled nursing and medical care on an inpatient basis, but only if that institution:
- Maintains on the premises all facilities necessary for medical treatment;
- Provides the treatment, for compensation, under the supervision of Physicians; and
- Provides Nurses’ services.

Specialist

A Physician who provides specialized services and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.
**Splint**

An appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

**Spouse**

Your legally married husband or wife.

**Note:** Tax treatment may vary for same-sex Spouses based on state law.

**Stabilize**

For an Emergency Medical Condition, to provide medical treatment of a condition as necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

**Substance Abuse Residential Treatment Center**

An institution that:

- Specializes in the treatment of psychological and social disturbances that are the result of substance abuse;
- Provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians;
- Provides 24-hour care in which a person lives in an open setting; and
- Is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when he/she is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

**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 be necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. This care includes, but is not limited to, dialysis, scheduled medical treatments or therapy or care received after a Physician’s recommendation that you should not travel due to any medical condition.