SchoolCare HEALTH BENEFIT PLANS

of the New Hampshire School Health Care Coalition

Health Benefits Booklet

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1. INTRODUCTION

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

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

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

Special Plan Provisions

Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

Case Management is a service provided through a Review Organization, which assists individuals with 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 an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which 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.

- 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, the Coalition, 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 Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish 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 the insurer, the patient, his or her family and 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.

Care Management and Care Coordination Services. Cigna may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing participants with certain care management and care coordination services to facilitate achievement of these goals. Reimbursement is provided at 100% for these services when rendered by designated health care professionals in these collaborative arrangements.

Additional Programs. The Coalition or Cigna may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well-being of our participants. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Participants. Contact us for details regarding any such arrangements.

Important Notices

Direct Access to Obstetricians and Gynecologists. You do not need prior authorization from Cigna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, 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. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact Cigna customer service at the phone number listed on the back of your ID card.

Selection of a Primary Care Provider. This 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 family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact Cigna customer service at the phone number listed on the back of your ID card.

Important Information

Rebates and Other Payments. Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals covered under your plan and Prescription Drugs included on the Prescription Drug List. These rebates or remuneration are not obtained on you or your Employer's or the Coalition's behalf or for your benefit. Cigna, its affiliates and the plan are not obligated to pass these rebates on to you or apply them to your plan's Deductible if any or take them into account in determining your Copayments and/or Coinsurance. Cigna and its affiliates or designees conduct business with various pharmaceutical manufacturers separate and apart from this plan's Medical Pharmaceutical and Prescription Drug benefits. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this plan. Cigna and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications. At various times, Cigna or its designee may send mailings to you or your Dependents or to your Physician that communicate a variety of messages, including information about Medical Pharmaceuticals and Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you or your Dependents, at your discretion, to purchase the described Medical Pharmaceutical and Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Cigna, its affiliates and the plan are not responsible in any way for any decision you make in connection with any coupon, incentive, or other offer you may receive from a pharmaceutical manufacturer or Physician.

If Cigna determines that a Pharmacy, pharmaceutical manufacturer or other third party is or has waived, reduced, or forgiven any portion of the charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you

are required to pay for a Prescription Drug without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of plan benefits in connection with the Prescription Drug, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the Pharmacy, pharmaceutical manufacturer or other third party represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by the plan. For example, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a Prescription Drug, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.

Discrimination is Against the Law. Cigna and the Coalition, in their roles as benefits administrator, comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna and the Coalition do not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna on behalf of the Coalition provides free aids and services to people with disabilities to communicate effectively with Cigna, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). They also provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Cigna Customer Service/Member Services at the toll-free phone number shown on your ID card, and ask an associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address: Cigna, Nondiscrimination Complaint Coordinator, P.O. Box 188016, Chattanooga, TN 37422.

If you need assistance filing a written grievance, please call the toll-free phone shown on your ID card or send an email to ACAGrievance@cigna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201; or by phone at 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Appointment of Authorized Representative. You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However, Cigna may require you to designate your authorized representative in writing using a form approved by Cigna. At all times, the appointment of an authorized representative is revocable by you. To ensure that a prior appointment remains valid, Cigna may require you to re-appoint your authorized representative, from time to time.

Cigna reserves the right to refuse to honor the appointment of a representative if Cigna reasonably determines that:

- the signature on an authorized representative form may not be yours, or
- the authorized representative may not have disclosed to you all of the relevant facts and circumstances relating to the overpayment or underpayment of any claim, including, for example, that the billing practices of the provider of medical services may have jeopardized your coverage through the waiver of the cost-sharing amounts that you are required to pay under your plan.

If your designation of an authorized representative is revoked, or Cigna does not honor your designation, you may appoint a new authorized representative at any time, in writing, using a form approved by Cigna.

How To File Your Claim

Your plan provides coverage when care is received only from In-Network providers, but you may still have Out-of-Network claims (for example, when Emergency Services are received from an Out-of-Network provider) and should follow the claim submission instructions for those claims. Claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.
You may get the required claim forms from the website listed on your identification card or by using the toll-free number on your identification card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.
- YOUR MEMBER ID IS THE ID SHOWN ON YOUR CIGNA IDENTIFICATION CARD.
- YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR CIGNA IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims
Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out- of-Network benefits, the claim will not be considered valid and will be denied.

2. DEFINITIONS

Brand Drug. A Prescription Drug that Cigna identifies as a Brand Drug across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the plan.

Business Decision Team. A committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to make decisions regarding coverage treatment of Prescription Drugs or Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to Prescription Drugs or Medical Pharmaceuticals.

Cigna HealthCare. Cigna HealthCare refers to various operating subsidiaries of Cigna Corporation. Products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C. and HMO or service company subsidiaries of Cigna Health Corporation. "Cigna Home Delivery Pharmacy" refers to a home delivery Network Pharmacy owned and operated by licensed Pharmacy affiliates of Cigna Health and Life Insurance Company. Tufts Health Plan is the trade name of a family of companies, including Tufts Associated Health Plans, Inc., Tufts Associated Health Maintenance Organization, Inc., Tufts Insurance Company, Tufts Benefit Administrators, Inc., and Total Health Plan, Inc. The Cigna Name, logo and other Cigna marks are owned by Cigna Intellectual Property, Inc.

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

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

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

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

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

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

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

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

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

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

(1) The spouse to whom the Subscriber is legally married; or,
(2) The Subscriber's partner in a valid New Hampshire marriage or in a civil union/marriage recognized by the state of New Hampshire.
(3) The Subscriber's child by blood or by law under the age of twenty-six (26); or,
(4) A Dependent qualified as a part-time or full-time student and on a medically necessary leave of absence from a public or private institution of higher learning for a period not to exceed the earlier of twelve (12) months or the end of the month following the Dependent's twenty-sixth (26^{th}) birthday. Documentation and certification of the medical necessity for the leave of absence must be submitted to the Coalition by the Dependent's attending physician and shall be considered prima facie evidence of entitlement to coverage under this subparagraph. The date of the documentation and certification of the medical leave of absence shall be the date eligibility commences under this subparagraph; or,
(5) Any individual twenty-six (26) or more years of age and continuously incapable of self-sustaining support because of a mental or physical handicap which existed prior to attaining age 26, provided that the disabled Dependent was covered by **SCHOOLCARE** at the time such coverage would have ended, and there has been no lapse of coverage. You must submit proof of the child's condition and dependence to Cigna within 30 days after the date the child ceases to qualify as a Dependent under the subsections listed above. Cigna may, from time to time require proof of the continuation of the child's condition and dependence, but not more frequently than once a year. Upon failure to submit required proof or when the child is no longer incapacitated, coverage with respect to the child shall cease.

The term child as used above includes the Subscriber's own child by natural birth; a child that is placed for adoption with the Subscriber; or a stepchild or foster child.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached. Anyone who is an Eligible Employee will not be considered a Dependent. No one may be considered as a Dependent of more than one Eligible Employee. Coverage is not provided for a newborn child of a Dependent, unless the Subscriber becomes the legal guardian of the child or legally adopts the child. For more information on Dependents, see Section 6.

Eligible Employee(s). That person or those persons designated by the employer and the Coalition as being eligible to enroll as Subscribers. Employee means a person in active service normally working 15 hours a week or more for the Employer.

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

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

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

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

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

Generic Drug. A Prescription Drug that Cigna identifies as a Generic Drug at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics (including Biosimilars) as either brand or generic based on a number of factors. Not all drugs identified as a "generic" by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the plan. A Biosimilar may be classified as a Generic Drug for the purposes of benefits under the plan even if it is identified as a "brand name" drug by the manufacturer, Pharmacy or your Physician.

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

Hospice Care Program. A coordinated, licensed, interdisciplinary program to meet the physical, psychological, spiritual and social needs of a terminally ill person and their family. Hospice Care provides palliative and supportive medical, nursing and other health services through home or inpatient care during illness. Includes bereavement counseling services provided as part of Hospice Care.

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

(1) A Hospital means a licensed institution that maintains on the premises all facilities necessary for medical and surgical treatment, provides such treatment on an inpatient basis for compensation under the supervision of Physicians, and provides 24-hour service by registered graduate nurses.
(2) An institution which qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital, and a provider of services under Medicare, if such institution is accredited as a Hospital by the Joint Commission on the Accreditation of Health Care Organizations; or,
(3) An institution that (a) specializes in treatment of mental health and substance use disorder or other related illness; (b) provides residential treatment programs and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

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

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

Maintenance Drug Products. A Prescription Drug Product that is prescribed for use over an extended period of time for the treatment of chronic or long-term conditions such as asthma, hypertension, diabetes and heart disease, and is identified principally based on consideration of available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source and clinical factors. For the purposes of benefits, the list of your plan's Maintenance Drug Products does not include compounded medications, Specialty Prescription Drug Products or Prescription Drug Products, such as certain narcotics that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or Refill under applicable federal or state law. You may determine whether a drug is a Maintenance Medication by calling Cigna member services at the telephone number on your ID card.

Maintenance Treatment. The term Maintenance Treatment means treatment rendered to keep or maintain a patient's current status.

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

Medical Pharmaceutical. An FDA-approved prescription pharmaceutical product, including a Specialty Prescription Drug, typically required to be administered in connection with a covered service by a Physician or other health care provider within the scope of the provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling. This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

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

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

Medically Necessary/Medical Necessity. Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:

(1) Required to diagnose or treat an illness, injury, disease or its symptoms;
(2) In accordance with generally accepted standards of medical practice;
(3) Clinically appropriate in terms of type, frequency, extent, site and duration;
(4) Not primarily for the convenience of the patient, Physician or other health care provider;
(5) Not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your sickness, Injury, condition, disease or its symptoms; and
(6) Rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

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

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

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

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

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

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

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

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

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

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

Participating Provider. A Health Care Professional, facility or institution, which has a direct or indirect contractual arrangement with Cigna to provide services with regard to a particular plan, including but not limited to Physicians, nurses, mental health professionals and Hospitals.

Pharmacy & Therapeutics (P&T) Committee. A committee of Participating Providers, pharmacists, Physician Reviewers and pharmacy directors, which regularly reviews Prescription Drugs and related supplies for safety, efficacy, cost effectiveness and value. The P&T Committee evaluates Prescription Drugs and related supplies for

addition to or deletion from the Formulary and may also set dosage and/or dispensing limits on Prescription Drugs and related supplies.

Physician. An individual who is a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if:

(1) Operating within the scope of his/her license; and
(2) Performing a service for which benefits are provided under this plan when performed by a Physician.

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

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

Prescription Drug. A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review, and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver.
For the purpose of benefits under the plan, this definition also includes:

(1) The following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips;
(2) Needles and syringes for self-administered medications or Biologics covered under the plan's Prescription Drug benefit; and
(3) Inhaler assistance devices and accessories, peak flow meters.

This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

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

Preventive Care Medications. The Prescription Drugs or other medications (including over-the-counter medications) designated as payable by the plan at 100% of the cost (without application of any Deductible, Copayment or Coinsurance) as required by applicable law under any of the following:

(1) 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.
(2) With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
(3) With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

A written prescription is required to process a claim for a Preventive Care Medication. You may determine whether a drug is a Preventive Care Medication through the internet website shown on your ID card or by calling member services at the telephone number on your ID card.

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

Primary Care Physician (PCP). A Physician, through an agreement with Cigna that practices general medicine, family medicine, internal medicine or pediatrics. A PCP is selected by you to provide or arrange for your medical care.

Prior Approval (also Prior Authorization or Pre-Certification). Depending on the SCHOOLCARE benefits you select, Prior Approval may be required before certain services are covered. Services that require Prior Approval include, but are not limited to:

(1) Inpatient Hospital services, except for 48/96-hour maternity stays or Other Health Care Facility;
(2) Inpatient services at any participating Other Health Care Facility;
(3) Residential treatment;
(4) Outpatient facility services, partial hospitalizations or intensive outpatient programs;
(5) Advanced radiological imaging;
(6) Non-emergency ambulance;
(7) Certain medical pharmaceuticals; or
(8) Transplant services.

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

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

(1) Marriage and/or divorce,
(2) Birth and/or death,
(3) Adoption of a child,
(4) Addition of stepchildren,
(5) Permanent legal custody of a child,
(6) Reinstatement of civilian status from active military personnel or
(7) When a Participant ceases to be a Dependent as defined above.

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

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

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

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

Review Organization. The term Review Organization refers to an affiliate of 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 graduate nurses, licensed mental health and substance use disorder professionals, and other trained staff who perform utilization review services.

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

Schedule of Benefits. A table or chart outlining SCHOOLCARE benefits, and certain exclusions (by way of example). There are separate Schedules of Benefits for the Green, Blue, Red and Yellow Open Access plans.

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

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

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

Specialty Prescription Drug. A Prescription Drug or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug based on consideration of the following factors, subject to applicable law: whether the Prescription Drug or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug or Medical Pharmaceutical has a high acquisition cost; and, whether the Prescription Drug or Medical Pharmaceutical is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug or Medical Pharmaceutical will be considered a Specialty Prescription Drug. Specialty Prescription Drugs may vary by plan benefit assignment based on factors such as method or site of clinical administration, or by tier assignment or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug through the website shown on your ID card or by calling Cigna member services at the telephone number on your ID card.

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

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

3. Schedules of Benefits

SCHOOLCARE Green Open Access Schedule of Benefits

The Green Open Access plan does not require that you select a Primary Care Physician (PCP) or obtain a referral from a PCP in order to receive all benefits available to you under this medical plan. Notwithstanding, a PCP may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependent(s). For this reason, we encourage the use of PCPs and provide you with the opportunity to select a PCP from a list provided by Cigna for yourself and your Dependent(s). 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.

Open Access In-Network Medical Benefits provide coverage for care In-Network (except in cases of Acupuncture, Emergency Care, and Urgent Care services). To receive Open Access In-Network Medical Benefits, you and your Dependent(s) may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment or Coinsurance.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

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

Copayments
Copayments are expenses to be paid by you and your Dependent(s) for covered services.

Contract Year
Contract Year means a twelve-month period beginning on each 07/01.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; or (ii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

You are responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). You are also responsible for all charges in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

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

Schedule of Benefits
SCHOOLCARE Green Open Access

BENEFIT HIGHLIGHTS	IN-NETWORK
Lifetime Maximum	**Unlimited**
	YOU PAY
Contract Year Deductible	
Individual	None
Family Maximum	None
Aggregate	No
Coinsurance	For Durable Medical Equipment and External Prosthetic Appliances (20%)
Out-of-Pocket Maximum	
Includes Coinsurance	Yes
Includes Deductible	Yes
Medical	
Individual	$1,000 per person
Family	$2,000 per family
Prescription	
Individual	$2,000 per person
Family	$4,000 per family
Aggregate Does Not Apply To	Non-compliance penalties
Preventive Care (Includes Naturopathic Services)	
Note: Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.	
Includes vision and hearing screenings for all ages.	
Includes preventive naturopathic services	
Routine Preventive Care – all ages	No charge
Immunizations – all ages	No charge
Routine Vision Care (includes refractions)	No charge after $10 office visit Copay
Eye Exam every 12 months	
Eyeglasses/Contact Lenses not covered	
Physician's Services (Includes Naturopathic Services)	
Primary Care Physician's Office Visit	No charge after $10 office visit Copay
Specialty Care Physician's Office Visit	No charge after $10 office visit Copay
Office Visits	
Consultant and Referral Physician's Services	
Surgery Performed in the Physician's Office	No charge after $10 office visit Copay
Allergy Treatment/Injections	No charge after either the office visit Copay or the actual charge, whichever is less
Allergy Serum (dispensed by the physician in the office)	No charge
Medical Telehealth	No charge after $10 office visit Copay
Routine Foot Care	No charge after $10 office visit Copay
Not covered, except for services associated with care of diabetes and peripheral vascular disease, when Medically Necessary	
Hearing Test	No charge after $10 office visit Copay
Laboratory and Radiology Services	No charge
Outpatient Pre-Admission Testing	
Primary Care Physician's Office Visit	No charge if only x-ray and/or lab services; $10 office visit Copay if other office visit services also provided

BENEFIT HIGHLIGHTS	IN-NETWORK
Specialist Physician's Office Visit	No charge if only x-ray and/or lab services; specialist $10 office visit Copay if other office visit services also provided
Outpatient Facility	No charge
Independent X-ray and/or Lab Facility	No charge
Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room, Treatment Room, and Observation Room*	No charge
Outpatient Professional Services *Surgeon, Radiologist, Pathologist, Anesthesiologist*	No charge
Inpatient Hospital - Facility Services *Semi-Private Room and Board*	No charge
Inpatient Hospital Physician's Visits/Consultations	No charge
Inpatient Hospital Professional Services *Surgeon, Radiologist, Pathologist, Anesthesiologist*	No charge
Inpatient Services at Other Health Care Facilities *Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities* *100 days combined maximum per Contract Year summary)*	No charge
Emergency and Urgent Care Services	
Physician's Office	No charge after $10 office visit Copay
Hospital Emergency Room	No charge after $50 per visit Copay (Copay waived if admitted)
Urgent Care Facility or Outpatient Facility	No charge after $25 per visit Copay (Copay waived if admitted)
Ambulance	No charge
Outpatient Short-Term Rehabilitative Therapy *60 days combined maximum per Contract Year; not applicable to mental health conditions* *Includes:* *Cardiac Rehab* *Physical Therapy* *Speech Therapy* *Occupational Therapy* *Pulmonary Therapy* *Cognitive Therapy*	No charge after $10 Copay Note: Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.
Chiropractic Therapy *20 days per Contract Year*	No charge after $10 Copay
Acupuncture* *12 days per Contract Year *Subject to Cigna HealthCare Guidelines. See Section 4.A.*	No charge after $10 Copay *Services can be obtained from a non-participating provider if they are licenses and/or certified. Pay out-of-network at the in-network benefits at billed charges.*
Home Health Care *(includes outpatient private duty nursing when approved by Cigna as Medically Necessary)*	No charge Unlimited days per contract year *Note: The maximum number of hours per day is limited to 16. Multiple visits can occur in one day, with a visit defined as a period of two hours or less (maximum of*
Hospice	
Inpatient Services	No charge
Outpatient Services	No charge
Maternity Care Services	
Initial Visit to Confirm Pregnancy	No charge after $10 office visit Copay
All subsequent Prenatal Visits, Postnatal Visits and Delivery (i.e. global maternity fee)	No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
Office visits in addition to the global maternity fee when performed by an OB or specialist	*You pay $10 per visit* *No charge if only x-ray and/or lab services performed and billed*
Delivery (Inpatient Hospital, Birthing Center)	No charge
Abortion *(Includes elective and non-elective procedures)*	
Office Visit	No charge after $10 office visit Copay
Inpatient Facility	No charge
Outpatient Surgical Facility	No charge
Physician's Services	No charge
Women's Family Planning Services	
Office Visit (tests, counseling)	No charge
Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.	
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)	
Inpatient Facility	No charge
Outpatient Facility	No charge
Physician's Services	No charge
Men's Family Planning Services	
Office Visit (tests, counseling)	No charge after $10 office visit Copay
Surgical Sterilization Procedures for Vasectomy (excludes reversals)	
Inpatient Facility	No charge
Outpatient Facility	No charge
Physician's Services	No charge
Breast Feeding Equipment and Supplies	
Rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	No charge
Infertility Treatment	
Coverage will be provided for the following services:	
Testing and treatment services performed in connection with an underlying medical condition;	
Testing performed specifically to determine the cause of infertility;	
Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition);	
Artificial Insemination.	
Office Visit (Test, Counseling) *Inpatient Facility* *Outpatient Facility*	No charge after specialist $10 office visit Copay No charge No charge
Services not covered include, but are not limited to, In-vitro, GIFT, ZIFT, and Infertility Drugs.	
Organ Transplants	Benefits provided through the Cigna LifeSOURCELifeSOURCE Organ Transplant Network, otherwise same as plan's Inpatient Hospital Facility benefit
Includes all medically appropriate, non-experimental transplants	
Office Visit	No charge after specialist $10 office visit Copay
Inpatient Facility	No charge
Inpatient Physician's Services	No charge
Travel Maximum	$10,000 per transplant/per lifetime maximum (only available when using a Cigna LifeSOURCE facility)
Durable Medical Equipment (DME)	Participant Coinsurance of 20%
Includes diabetes equipment. Coverage for self-management training and educational services must be provided, upon written order of a provider, including medical nutritional therapy.	

BENEFIT HIGHLIGHTS	IN-NETWORK
External Prosthetic Appliances	Participant Coinsurance of 20%
Dental Care *Charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.* *Removal of boney impacted wisdom teeth.*	(Prior authorization Required for Dental Care)
Physician's Office	No charge after $10 office visit Copay
Inpatient Facility	No charge
Outpatient surgical Facility	No charge
Physician's Services	No charge
Prescription Drugs *Cigna Pharmacy Retail Drug Program* *Medications required as part of preventive care services are covered at 100% with no copayment or deductible (a detailed listing is available at www.healthcare.gov)* *Certain Specialty Prescription Drugs are only covered when dispensed by a home delivery Pharmacy, after 1 fill at a retail Pharmacy. Specialty Prescription Drugs are limited to up to a consecutive 30-day supply per fill.*	$5 per 30-day supply for generic drugs $15 per 30-day supply for preferred brand name drugs $35 per 30-day supply for non-preferred brand name drugs Go to Cigna.com/Rx90network for a retail Designated Pharmacy listing. These Designated Pharmacies may dispense a 90-day supply of covered Maintenance Drug Products.
Cigna Home Delivery Program *Mail Order Program* *Medications required as part of preventive care services are covered at 100% with no copayment or deductible (a detailed listing is available at www.healthcare.gov)*	$5 per 90-day supply for generic drugs $15 per 90-day supply for preferred brand name drugs $35 per 90-day supply for non-preferred brand name drugs
Mental Health/ Substance Use Disorder	
Inpatient Hospitalization and Outpatient Facility	No charge
Outpatient (Physician's office)	No charge after $10 office visit Copay
Behavioral Telehealth Consultation	No charge after $10 office visit Copay
Pre-Existing Condition Limitation	Not Applicable
Pre-Admission Certification-Continued Stay Review required for all Inpatient Admissions	Coordinated by Participating Provider, PCP and Cigna
Prior Authorization required for selected outpatient procedures and diagnostic testing	Coordinated by Participating Provider, PCP and Cigna
Case Management	Coordinated by Cigna. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.

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

SCHOOLCARE Red Open Access Schedule of Benefits

In the Red Open Access plan, you do not need to select a Primary Care Physician (PCP). Notwithstanding, a PCP may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependent(s). For this reason, we encourage the use of PCPs and provide you with the opportunity to select a PCP from a list provided by Cigna for yourself and your Dependent(s). 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.

No Referrals are necessary to receive Covered Services from other providers in the Cigna Open Access network. The plan encourages use of Preventive Care, with no Deductibles, Copayments or Coinsurance. Other Covered Services are subject to a Deductible and Coinsurance until you reach an out-of-pocket maximum for the Contract Year. Open Access In-Network Medical Benefits provide coverage for care In-Network (except in cases of Acupuncture, Emergency Care, and Urgent Care services). To receive Open Access In-Network Medical Benefits, you and your Dependent(s) may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

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

Copayments/Deductibles
Copayments are expenses to be paid by you and your Dependent(s) for covered services. Deductibles are also expenses to be paid by you or your Dependent(s). Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

Contract Year
Contract Year means a twelve-month period beginning on each 07/01.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; or (ii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

You are responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). You are also responsible for all charges in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

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

Schedule of Benefits
SCHOOLCARE RED OPEN ACCESS

BENEFIT HIGHLIGHTS	IN-NETWORK
Lifetime Maximum	***Unlimited***
	YOU PAY
Contract Year Deductible	
Individual	$250
Family	$500
Aggregate	Yes
Coinsurance	20%
Out-of-Pocket Maximum	
Includes Coinsurance	Yes
Includes Deductible	Yes
Medical	
Individual	$1,000 per person
Family	$2,000 per family
Prescription	
Individual	$2,000 per person
Family	$4,000 per family
Aggregate Does Not Apply To	Non-compliance penalties
Preventive Care (Includes Naturopathic Services)	
Note: Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.	$0
Includes vision and hearing screenings for all ages.	
Routine Preventive Care – all ages	
Routine Vision Care (includes refractions)	$0
Eye Exam every 12 months	
Eyeglasses/Contact Lenses not covered	
Hearing Test	$0
Routine Foot Care	Deductible, then 20% to the Out-of-Pocket Maximum
Not covered, except for services associated with care of diabetes and peripheral vascular disease, when Medically Necessary	
Physician's Services (Includes Naturopathic Services)	
Primary Care Physician's Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum
Specialty Care Physician's Office Visit	
Office Visits	Deductible, then 20% to the Out-of-Pocket Maximum
Consultant and Referral Physician's Services	Deductible, then 20% to the Out-of-Pocket Maximum
Surgery Performed in the Physician's Office	Deductible, then 20% to the Out-of-Pocket Maximum
Allergy Treatment/Injections	Deductible, then 20% to the Out-of-Pocket Maximum
Allergy Serum (dispensed by the physician in the office)	Deductible, then 20% to the Out-of-Pocket Maximum
Medical Telehealth	Deductible, then 20% to the Out-of-Pocket Maximum
Laboratory and Radiology Services	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Pre-Admission Testing	
Primary Care Physician's Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum
Specialist Physician's Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Independent X-ray and/or Lab Facility	Deductible, then 20% to the Out-of-Pocket Maximum

BENEFIT HIGHLIGHTS	IN-NETWORK
Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room, Treatment Room, and Observation Room*	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Professional Services *Surgeon, Radiologist, Pathologist, Anesthesiologist*	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Hospital - Facility Services *Semi-Private Room and Board*	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Hospital Physician's Visits/Consultations	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Hospital Professional Services *Surgeon, Radiologist, Pathologist, Anesthesiologist*	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Services at Other Health Care Facilities *Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities* *100 days combined maximum per Contract Year*	Deductible, then 20% to the Out-of-Pocket Maximum
Emergency and Urgent Care Services *Physician's Office* *Hospital Emergency Room* *Urgent Care Facility or Outpatient Facility* *Ambulance*	 Deductible, then 20% to the Out-of-Pocket Maximum No charge after $50 per visit Copay (Copay waived if admitted) No charge after $25 per visit Copay (Copay waived if admitted) Deductible, then 20% to the Out-of-Pocket Maximum*
Outpatient Short-Term Rehabilitative Therapy *60 days combined maximum per Contract Year; not applicable to mental health conditions* *Includes:* *Cardiac Rehab* *Physical Therapy* *Speech Therapy* *Occupational Therapy* *Pulmonary Therapy* *Cognitive Therapy*	Deductible, then 20% to the Out-of-Pocket Maximum Note: Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.
Chiropractic Therapy *20 days per Contract Year*	Deductible then 20% to the Out-of-Pocket Maximum
Acupuncture* *12 days per Contract Year *Subject to Cigna HealthCare Guidelines. See Section 4. A.*	Deductible, then 20% to the Out-of-Pocket Maximum *Services can be obtained from a non-participating provider if they are licenses and/or certified. Pay out-of-network at the in-network benefits at billed charges.*
Home Health Care *(includes outpatient private duty nursing when approved by Cigna as Medically Necessary)* *Unlimited days per contract year* *Note: The maximum number of hours per day is limited to 16. Multiple visits can occur in one day, with a visit defined as a period of two hours or less (maximum of eight visits per day).*	Deductible, then 20% to the Out-of-Pocket Maximum
Hospice *Inpatient Services* *Outpatient Services*	 Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum
Maternity Care Services *Initial Visit to Confirm Pregnancy* *All subsequent Prenatal Visits, Postnatal Visits and Delivery (i.e. global maternity)* *Office visits in addition to the global maternity fee when performed by an OB or specialist* *Delivery (Inpatient Hospital, Birthing Center)*	 Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum

BENEFIT HIGHLIGHTS	IN-NETWORK
Abortion *(Includes elective and non-elective procedures)*	
Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Surgical Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Physician's Services	Deductible, then 20% to the Out-of-Pocket Maximum
Women's Family Planning Services	
Office Visit (tests, counseling)	No charge
Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.	
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)	
Inpatient Facility	No charge
Outpatient Facility	No charge
Physician's Services	No charge
Men's Family Planning Services	
Office Visit (tests, counseling)	Deductible, then 20% to the Out-of-Pocket Maximum
Surgical Sterilization Procedures for Vasectomy (excludes reversals)	
Inpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Physician's Services	Deductible, then 20% to the Out-of-Pocket Maximum
Breast Feeding Equipment and Supplies	
Rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	No charge
Infertility Treatment	
Coverage will be provided for the following services:	
Testing and treatment services performed in connection with an underlying medical condition;	
Testing performed specifically to determine the cause of infertility;	
Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition);	
Artificial Insemination.	
Office Visit (Test, Counseling)	
Inpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Services not covered include, but are not limited to, In-vitro, GIFT, ZIFT, and Infertility Drugs	Deductible, then 20% to the Out-of-Pocket Maximum
Organ Transplants	Benefits provided through the Cigna LifeSOURCE Organ Transplant Network, otherwise same as plan's Inpatient Hospital Facility benefit
Includes all medically appropriate, non-experimental transplants	
Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Physician's Services	Deductible, then 20% to the Out-of-Pocket Maximum
Travel Maximum	$10,000 per transplant/per lifetime maximum (only available when using a Cigna LifeSOURCE facility)
Durable Medical Equipment (DME)	Deductible, then 20% to the Out-of-Pocket Maximum
Includes diabetes equipment. Coverage for self-management training and educational services must be provided, upon written order of a provider, including medical nutritional therapy.	

BENEFIT HIGHLIGHTS	IN-NETWORK
External Prosthetic Appliances	Deductible, then 20% to the Out-of-Pocket Maximum
Dental Care	(Prior Authorization Required for Dental Care)
Charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.	
Removal of boney impacted wisdom teeth.	
Physician's Office	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient surgical Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Physician's Services	Deductible, then 20% to the Out-of-Pocket Maximum
Prescription Drugs	
Cigna Pharmacy Retail Drug Program	$5 per 30-day supply for generic drugs $15 per 30-day supply for preferred brand name drugs $35 per 30-day supply for non-preferred brand name drugs
Medications required as part of preventive care services are covered at 100% with no copayment or deductible (a detailed listing is available atwww.healthcare.gov)	
Certain Specialty Prescription Drugs are only covered when dispensed by a home delivery Pharmacy, after 1 fill at a retail Pharmacy. Specialty Prescription Drugs are limited to up to a consecutive 30-day supply per fill.	Go to Cigna.com/Rx90network for a retail Designated Pharmacy listing. These Designated Pharmacies may dispense a 90-day supply of covered Maintenance Drug Products.
Cigna Home Delivery Program	
Mail Order Program	$0 per 90-day supply for generic drugs $15 per 90-day supply for preferred brand name drugs $35 per 90-day supply for non-preferred brand name drugs
Medications required as part of preventive care services are covered at 100% with no copayment or deductible (a detailed listing is available at www.healthcare.gov)	
Mental Health/ Substance Use Disorder	
Inpatient Hospitalization and Outpatient Facility	$0
Outpatient (Physician's office)	$0
Behavioral Telehealth Consultation	$0
Pre-Existing Condition Limitation	Not Applicable
Pre-Admission Certification-Continued Stay Review required for all Inpatient Admissions	Coordinated by Participating Provider and Cigna
Prior Authorization required for selected outpatient procedures and diagnostic testing.	Coordinated by Participating Provider and Cigna
Case Management	Coordinated by Cigna. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.

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

SCHOOLCARE Yellow Open Access Schedule of Benefits

In the Yellow Open Access plan, you do not need to select a Primary Care Physician (PCP). Notwithstanding, a PCP may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependent(s). For this reason, we encourage the use of PCPs and provide you with the opportunity to select a PCP from a list provided by Cigna for yourself and your Dependent(s). 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.

No Referrals are necessary to receive Covered Services from other providers in the Cigna Open Access network. The plan encourages use of Preventive Care, with no Deductibles, Copayments or Coinsurance. Other Covered Services are subject to a Deductible and Coinsurance until you reach an out-of-pocket maximum for the Contract Year. Open Access In-Network Medical Benefits provide coverage for care In-Network (except in cases of Acupuncture, Emergency Care, and Urgent Care services). To receive Open Access In-Network Medical Benefits, you and your Dependent(s) may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Choice Fund - Health Reimbursement Account (HRA)
Your employer may establish a HRA ($1,000 Individual/$2,000 Family), that can be used to pay the first portion of eligible out-of-pocket expenses during the Contract Year.

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

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

Contract Year
Contract Year means a twelve-month period beginning on each 07/01.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; or (ii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

You are responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). You are also responsible for all charges in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

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

Schedule of Benefits
SCHOOLCARE YELLOW OPEN ACCESS

BENEFIT HIGHLIGHTS	IN-NETWORK
Lifetime Maximum	***Unlimited***
	YOU PAY
Contract Year Deductible	
Individual	$1,250
Family	$2,500
Aggregate	Yes
Coinsurance	
Medical	20%
Prescription	10%
Out-of-Pocket Maximum	
Includes Coinsurance	Yes
Includes Deductible	Yes
Medical & Prescription (Combined)	
Individual	$2,000 per person
Family	$4,000 per family
Aggregate Does Not Apply To	Non-compliance penalties
Preventive Care (Includes Naturopathic Services)	
Note: Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.	$0
Includes vision and hearing screenings for all ages.	
Routine Preventive care – all ages	$0
Immunizations – all ages	$0
Routine Vision Care (includes refractions)	$0
Eye Exam every 12 months	
Eyeglasses/Contact Lenses not covered	
Hearing Test	Deductible, then 20% to the Out-of-Pocket Maximum
Routine Foot Care	Deductible, then 20% to the Out-of-Pocket Maximum
Not covered, except for services associated with care of diabetes and peripheral vascular disease, when Medically Necessary	
Physician's Services (Includes Naturopathic Services)	
Primary Care Physician's Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum
Specialty Care Physician's Office Visit	
Office Visits	Deductible, then 20% to the Out-of-Pocket Maximum
Consultant and Referral Physician's Services	Deductible, then 20% to the Out-of-Pocket Maximum
Surgery Performed in the Physician's Office	Deductible, then 20% to the Out-of-Pocket Maximum
Allergy Treatment/Injections	Deductible, then 20% to the Out-of-Pocket Maximum
Allergy Serum (dispensed by the physician in the office)	Deductible, then 20% to the Out-of-Pocket Maximum
Medical Telehealth	Deductible, then 20% to the Out-of-Pocket Maximum
Laboratory and Radiology Services	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Pre-Admission Testing	
Primary Care Physician's Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum
Specialist Physician's Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum

BENEFIT HIGHLIGHTS	IN-NETWORK
Outpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Independent X-ray and/or Lab Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room, Treatment Room, and Observation Room*	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Professional Services *Surgeon, Radiologist, Pathologist, Anesthesiologist*	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Hospital - Facility Services *Semi-Private Room and Board*	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Hospital Physician's Visits/Consultations	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Hospital Professional Services *Surgeon, Radiologist, Pathologist, Anesthesiologist*	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Services at Other Health Care Facilities *Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities* *100 days combined maximum per Contract Year*	Deductible, then 20% to the Out-of-Pocket Maximum
Emergency and Urgent Care Services	
Physician's Office	Deductible, then 20% to the Out-of-Pocket Maximum
Hospital Emergency Room	Deductible, then 20% to the Out-of-Pocket Maximum
Urgent Care Facility or Outpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Ambulance	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Short-Term Rehabilitative Therapy *60 days combined maximum per Contract Year; not applicable to mental health conditions* *Includes:* *Cardiac Rehab* *Physical Therapy* *Speech Therapy* *Occupational Therapy* *Pulmonary Therapy* *Cognitive Therapy*	Deductible, then 20% to the Out-of-Pocket Maximum Note: Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.
Chiropractic Therapy *20 days per Contract Year*	Deductible then 20% to the Out-of-Pocket Maximum
Acupuncture* *12 days per Contract Year* **Subject to Cigna HealthCare Guidelines. See Section 4. A.*	Deductible, then 20% to the Out-of-Pocket Maximum *Services can be obtained from a non-participating provider if they are licenses and/or certified. Pay out-of-network at the in-network benefits at billed charges.*
Home Health Care *(includes outpatient private duty nursing when approved by Cigna as Medically Necessary)* *Unlimited days per contract year* *Note: The maximum number of hours per day is limited to 16. Multiple visits can occur in one day, with a visit defined as a period of two hours or less (maximum of eight visits per day).*	Deductible, then 20% to the Out-of-Pocket Maximum
Hospice	
Inpatient Services	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Services	Deductible, then 20% to the Out-of-Pocket Maximum
Maternity Care Services	
Initial Visit to Confirm Pregnancy	Deductible, then 20% to the Out-of-Pocket Maximum
All subsequent Prenatal Visits, Postnatal Visits and Delivery (i.e. global maternity)	Deductible, then 20% to the Out-of-Pocket Maximum

BENEFIT HIGHLIGHTS	IN-NETWORK
Office visits in addition to the global maternity fee when performed by an OB or specialist	Deductible, then 20% to the Out-of-Pocket Maximum
Delivery (Inpatient Hospital, Birthing Center)	Deductible, then 20% to the Out-of-Pocket Maximum
***Abortion** (Includes elective and non-elective procedures)*	
Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Surgical Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Physician's Services	Deductible, then 20% to the Out-of-Pocket Maximum
Women's Family Planning Services	
Office Visit (tests, counseling)	No charge
Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.	
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)	
Inpatient Facility	No charge
Outpatient Facility	No charge
Physician's Services	No charge
Men's Family Planning Services	Deductible, then 20% to the Out-of-Pocket Maximum
Office Visit (tests, counseling)	
Surgical Sterilization Procedures for Vasectomy (excludes reversals)	
Inpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Physician's Services	Deductible, then 20% to the Out-of-Pocket Maximum
Breast Feeding Equipment and Supplies	
Rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	No charge
Infertility Treatment	
Coverage will be provided for the following services:	
Testing and treatment services performed in connection with an underlying medical condition;	
Testing performed specifically to determine the cause of infertility;	
Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition);	
Artificial Insemination.	
Office Visit (Test, Counseling)	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Services not covered include, but are not limited to, In-vitro, GIFT, ZIFT, and Infertility Drugs	
Organ Transplants	Benefits provided through the Cigna LifeSOURCE Organ Transplant Network, otherwise same as plan's Inpatient Hospital Facility benefit
Includes all medically appropriate, non-experimental transplants	
Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Physician's Services	Deductible, then 20% to the Out-of-Pocket Maximum
Travel Maximum	$10,000 per transplant/per lifetime maximum (only available when using a Cigna LifeSOURCE facility)

BENEFIT HIGHLIGHTS	IN-NETWORK
Durable Medical Equipment (DME) *Includes diabetes equipment. Coverage for self-management training and educational services must be provided, upon written order of a provider, including medical nutritional therapy.*	Deductible, then 20% to the Out-of-Pocket Maximum
External Prosthetic Appliances	Deductible, then 20% to the Out-of-Pocket Maximum
Dental Care *Charges made for a continuous course of dental treatment started within six months of an injury to teeth.* *Removal of boney impacted wisdom teeth.* *Physician's Office* *Inpatient Facility* *Outpatient surgical Facility* *Physician's Services*	(Prior Authorization Required for Dental Care) Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum
Prescription Drugs *Cigna Pharmacy Retail Drug Program* *Medications required as part of preventive care services are covered at 100% with no copayment or deductible (a detailed listing is available at www.healthcare.gov)* *Certain Specialty Prescription Drugs are only covered when dispensed by a home delivery Pharmacy, after 1 fill at a retail Pharmacy. Specialty Prescription Drugs are limited to up to a consecutive 30-day supply per fill.*	 Deductible, then 10% to the Out-of-Pocket Maximum** **$75 maximum after deductible Go to Cigna.com/Rx90network for a retail Designated Pharmacy listing. These Designated Pharmacies may dispense a 90-day supply of covered Maintenance Drug Products.
Cigna Home Delivery Program *Mail Order Program* *Medications required as part of preventive care services are covered at 100% with no copayment or deductible (a detailed listing is available at www.healthcare.gov)*	 Deductible, then 10% to the Out-of-Pocket Maximum** **$75 maximum after deductible
Mental Health/ Substance Use Disorder *Inpatient Hospitalization and Outpatient Facility* *Outpatient (Physician's office)* *Behavioral Telehealth Consultation*	 Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum
Pre-Existing Condition Limitation	Not Applicable
Pre-Admission Certification-Continued Stay Review required for all Inpatient Admissions	Coordinated by Participating Provider and Cigna
Prior Authorization required for selected outpatient procedures and diagnostic testing.	Coordinated by Participating Provider and Cigna
Case Management	Coordinated by Cigna. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.

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

SCHOOLCARE Orange Open Access Schedule of Benefits

In the Orange Open Access plan, you do not need to select a Primary Care Physician (PCP). Notwithstanding, a PCP may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependent(s). For this reason, we encourage the use of PCPs and provide you with the opportunity to select a PCP from a list provided by Cigna for yourself and your Dependent(s). 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.

No Referrals are necessary to receive Covered Services from other providers in the Cigna Open Access network. The plan encourages use of Preventive Care, with no Deductibles, Copayments or Coinsurance. Other Covered Services are subject to a Deductible and Coinsurance until you reach an out-of-pocket maximum for the Contract Year. Open Access In-Network Medical Benefits provide coverage for care In-Network (except in cases of Acupuncture, Emergency Care, and Urgent Care services). To receive Open Access In-Network Medical Benefits, you and your Dependent(s) may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Choice Fund - Health Reimbursement Account (HRA)
Your employer may establish a HRA ($1,000 Individual/$2,000 Family), that can be used to pay the first portion of eligible out-of-pocket expenses during the Contract Year.

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

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

Contract Year
Contract Year means a twelve-month period beginning on each 07/01.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; or (ii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

You are responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). You are also responsible for all charges in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

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

Schedule of Benefits
SCHOOLCARE ORANGE OPEN ACCESS

BENEFIT HIGHLIGHTS	IN-NETWORK
Lifetime Maximum	***Unlimited***
	YOU PAY
Contract Year Deductible	
Individual	$2,000
Family	$4,000
Aggregate	Yes
Coinsurance	
Medical	20%
Prescription	10%
Out-of-Pocket Maximum	
Includes Coinsurance	Yes
Includes Deductible	Yes
Medical & Prescription (Combined)	
Individual	$4,000 per person
Family	$8,000 per family
Aggregate Does Not Apply To	Non-compliance penalties
Preventive Care (Includes Naturopathic Services)	
Note: Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.	$0
Includes vision and hearing screenings for all ages.	
Routine Preventive care – all ages	$0
Immunizations – all ages	$0
Routine Vision Care (includes refractions)	$0
Eye Exam every 12 months	
Eye Glasses/Contact Lenses not covered	
Hearing Test	Deductible, then 20% to the Out-of-Pocket Maximum
Routine Foot Care	Deductible, then 20% to the Out-of-Pocket Maximum
Not covered, except for services associated with care of diabetes and peripheral vascular disease, when Medically Necessary	
Physician's Services (Includes Naturopathic Services)	
Primary Care Physician's Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum
Specialty Care Physician's Office Visit	
Office Visits	Deductible, then 20% to the Out-of-Pocket Maximum
Consultant and Referral Physician's Services	Deductible, then 20% to the Out-of-Pocket Maximum
Surgery Performed in the Physician's Office	Deductible, then 20% to the Out-of-Pocket Maximum
Allergy Treatment/Injections	Deductible, then 20% to the Out-of-Pocket Maximum
Allergy Serum (dispensed by the physician in the office)	Deductible, then 20% to the Out-of-Pocket Maximum
Medical Telehealth	Deductible, then 20% to the Out-of-Pocket Maximum
Laboratory and Radiology Services	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Pre-Admission Testing	
Primary Care Physician's Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum
Specialist Physician's Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum

BENEFIT HIGHLIGHTS	IN-NETWORK
Outpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Independent X-ray and/or Lab Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room, Treatment Room, and Observation Room*	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Professional Services *Surgeon, Radiologist, Pathologist, Anesthesiologist*	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Hospital - Facility Services *Semi-Private Room and Board*	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Hospital Physician's Visits/Consultations	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Hospital Professional Services *Surgeon, Radiologist, Pathologist, Anesthesiologist*	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Services at Other Health Care Facilities *Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities* *100 days combined maximum per Contract Year*	Deductible, then 20% to the Out-of-Pocket Maximum
Emergency and Urgent Care Services	
Physician's Office	Deductible, then 20% to the Out-of-Pocket Maximum
Hospital Emergency Room	Deductible, then 20% to the Out-of-Pocket Maximum
Urgent Care Facility or Outpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Ambulance	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Short-Term Rehabilitative Therapy *60 days combined maximum per Contract Year; not applicable to mental health conditions* *Includes:* *Cardiac Rehab* *Physical Therapy* *Speech Therapy* *Occupational Therapy* *Pulmonary Therapy* *Cognitive Therapy*	Deductible, then 20% to the Out-of-Pocket Maximum Note: Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.
Chiropractic Therapy *20 days per Contract Year*	Deductible then 20% to the Out-of-Pocket Maximum
Acupuncture* *12 days per Contract Year* **Subject to Cigna HealthCare Guidelines. See Section 4. A.*	Deductible, then 20% to the Out-of-Pocket Maximum *Services can be obtained from a non-participating provider if they are licenses and/or certified. Pay out-of-network at the in-network benefits at billed charges.*
Home Health Care *(includes outpatient private duty nursing when approved by Cigna as Medically Necessary)* *Unlimited days per contract year* *Note: The maximum number of hours per day is limited to 16. Multiple visits can occur in one day, with a visit defined as a period of two hours or less (maximum of eight visits per day).*	Deductible, then 20% to the Out-of-Pocket Maximum
Hospice	
Inpatient Services	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Services	Deductible, then 20% to the Out-of-Pocket Maximum
Maternity Care Services	
Initial Visit to Confirm Pregnancy	Deductible, then 20% to the Out-of-Pocket Maximum
All subsequent Prenatal Visits, Postnatal Visits and Delivery (i.e. global maternity)	Deductible, then 20% to the Out-of-Pocket Maximum

BENEFIT HIGHLIGHTS	IN-NETWORK
Office visits in addition to the global maternity fee when performed by an OB or specialist	Deductible, then 20% to the Out-of-Pocket Maximum
Delivery (Inpatient Hospital, Birthing Center)	Deductible, then 20% to the Out-of-Pocket Maximum
Abortion *(Includes elective and non-elective procedures)*	
Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Surgical Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Physician's Services	Deductible, then 20% to the Out-of-Pocket Maximum
Women's Family Planning Services	
Office Visit (tests, counseling)	No charge
Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.	
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)	
Inpatient Facility	No charge
Outpatient Facility	No charge
Physician's Services	No charge
Men's Family Planning Services	Deductible, then 20% to the Out-of-Pocket Maximum
Office Visit (tests, counseling)	
Surgical Sterilization Procedures for Vasectomy (excludes reversals)	
Inpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Physician's Services	Deductible, then 20% to the Out-of-Pocket Maximum
Breast Feeding Equipment and Supplies	
Rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	No charge
Infertility Treatment	
Coverage will be provided for the following services:	
Testing and treatment services performed in connection with an underlying medical condition;	
Testing performed specifically to determine the cause of infertility;	
Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition);	
Artificial Insemination.	
Office Visit (Test, Counseling)	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Outpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Services not covered include, but are not limited to, In-vitro, GIFT, ZIFT, and Infertility Drugs	
Organ Transplants	Benefits provided through the Cigna LifeSOURCE Organ Transplant Network, otherwise same as plan's Inpatient Hospital Facility benefit
Includes all medically appropriate, non-experimental transplants	
Office Visit	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Facility	Deductible, then 20% to the Out-of-Pocket Maximum
Inpatient Physician's Services	Deductible, then 20% to the Out-of-Pocket Maximum
Travel Maximum	$10,000 per transplant/per lifetime maximum (only available when using a Cigna LifeSOURCE facility)

BENEFIT HIGHLIGHTS	IN-NETWORK
Durable Medical Equipment (DME) *Includes diabetes equipment. Coverage for self-management training and educational services must be provided, upon written order of a provider, including medical nutritional therapy.*	Deductible, then 20% to the Out-of-Pocket Maximum
External Prosthetic Appliances	Deductible, then 20% to the Out-of-Pocket Maximum
Dental Care *Charges made for a continuous course of dental treatment started within six months of an injury to teeth.* *Removal of boney impacted wisdom teeth.* *Physician's Office* *Inpatient Facility* *Outpatient surgical Facility* *Physician's Services*	(Prior Authorization Required for Dental Care) Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum
Prescription Drugs *Cigna Pharmacy Retail Drug Program* *Medications required as part of preventive care services are covered at 100% with no copayment or deductible (a detailed listing is available at www.healthcare.gov)* *Certain Specialty Prescription Drugs are only covered when dispensed by a home delivery Pharmacy, after 1 fill at a retail Pharmacy. Specialty Prescription Drugs are limited to up to a consecutive 30-day supply per fill.*	Deductible, then 10% to the Out-of-Pocket Maximum** **$75 maximum after deductible Go to Cigna.com/Rx90network for a retail Designated Pharmacy listing. These Designated Pharmacies may dispense a 90-day supply of covered Maintenance Drug Products.
Cigna Home Delivery Program *Mail Order Program* *Medications required as part of preventive care services are covered at 100% with no copayment or deductible (a detailed listing is available at www.healthcare.gov)*	Deductible, then 10% to the Out-of-Pocket Maximum** **$75 maximum after deductible
Mental Health/ Substance Use Disorder *Inpatient Hospitalization and Outpatient Facility* *Outpatient (Physician's office)* *Behavioral Telehealth Consultation*	 Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum Deductible, then 20% to the Out-of-Pocket Maximum
Pre-Existing Condition Limitation	Not Applicable
Pre-Admission Certification-Continued Stay Review required for all Inpatient Admissions	Coordinated by Participating Provider and Cigna
Prior Authorization required for selected outpatient procedures and diagnostic testing.	Coordinated by Participating Provider and Cigna
Case Management	Coordinated by Cigna. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.

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

Benefit Exclusions

All SCHOOLCARE plans provide coverage for Medically Necessary services.

The SCHOOLCARE plans do not provide coverage for the following (*by way of example, but not limited to*):

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

   In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.
9. Cosmetic Services and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance.
10. The following services are excluded from coverage regardless of clinical indications: acupressure; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
11. Treatment of TMJ disorder. But see Section 5. B. (3) of this Health Benefits Booklet.
12. Dental treatment of the teeth, gums or structures directly supporting the teeth including, but not limited to, dental x-rays, examinations, repairs, extractions, orthodontics, dental implants, periodontics, casts, splints and services for dental malocclusion for any condition. Exceptions: Removal of boney impacted wisdom teeth is a Covered Service. Also, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% boney support and are functional in the arch. Dental implants are not covered for any condition.
13. Reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.
14. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician and approved by Cigna.
15. Infertility drugs, in vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and variations of these procedures, services when the infertility is caused by or related to voluntary sterilization, and donor charges and services. Cryopreservation of donor sperm and eggs are also excluded.
16. Reversal of male and female voluntary sterilization procedures.
17. Treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.
18. Medical and Hospital care and costs for the infant child of a Dependent.
19. Non-medical counseling or ancillary services including, but not limited to, Custodial Services, education services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return-to-work services, work hardening programs, and driver safety courses.
20. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance including, but not limited, to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
21. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in Section 4 of this Health Benefits Booklet.

22. Private hospital rooms and/or private duty nursing unless approved by the Cigna Physician Reviewer.
23. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
24. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, garter belts, corsets and dentures.
25. 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.
26. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
27. Eye exercises and surgical treatment for the correction of refractive errors including radial keratotomy.
28. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
29. Orthotic devices, except as otherwise noted in Section 4. N.
30. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
31. Ultrasound or any other procedures requested solely for sex determination of the fetus.
32. Genetic screening or pre-implantation genetic screening, except as otherwise noted in Section 4. A. 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.
33. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where, in the Cigna Physician Reviewer's opinion, the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
34. Blood administration for the purpose of general improvement in physical condition.
35. Physical examinations, the cost of biologicals that are immunizations or medications, and all other medical services required for the purpose of travel, employment or by other third parties including protection against occupational hazards and risks.
36. Cosmetics, dietary supplements and health and beauty aids.
37. Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan. See Section 11, Coordination of Benefits.
38. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
39. Charges in excess of Reasonable and Customary.
40. Massage Therapy.

4. BENEFITS AND SERVICES (additional information)

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

A. Outpatient Services.

(1) Adult and pediatric health examinations.

(2) Diagnosis and treatment services, including lab and X-ray.

(3) Charges for genetic testing that use proven testing methods for the identification of genetically linked inheritable disease. Genetic testing is covered only if a person has symptoms or signs of a genetically linked inheritable disease; it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based scientific literature for the development of a genetically linked inheritable disease when the results will impact clinical outcome; or the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence–based scientific literature to directly impact treatment options. Pre-implantation genetic testing, genetic diagnosis prior to 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 the Participant is undergoing approved genetic testing, or has an inherited disease, or is a potential candidate for genetic testing. Genetic counseling is limited to three visits per Contract Year for both pre- and post-genetic testing; however, the 3-visit limit will not apply to Mental Health and Substance Use Disorder conditions.

(4) Family planning services including medical history, physical examination, related laboratory tests, medical supervision and other medical services in accordance with generally accepted medical practice. Also included under family planning services: information and counseling on contraception, implanted/injected contraceptives, and after appropriate counseling, medical services connected with surgical therapies (vasectomy or tubal ligation).

(5) Short-term nutritional evaluation and counseling. Information and pre-approved health education rendered by a licensed or certified provider when diet is a part of the medical management of a documented organic disease, including clinically severe obesity, asthma, high cholesterol and diabetes.

(6) Diabetic services including self-management training, which provide instruction about the disease and its control, educational services and medical nutritional therapy. Diabetic supplies, including blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading, urine testing strips, insulin, injection aids, cartridges for the visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices and oral agents for controlling blood sugar.

(7) Immunizations and injections for the prevention and detection of diseases. But see Section 5. A. (24).

(8) Maternity care, including medical, surgical and Hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy.

(9) Outpatient surgical services, including anesthesia and recovery room services in a Hospital or Outpatient Surgical Facility.

(10) Short-term Outpatient Rehabilitative Services that are part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulation, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most Medically Appropriate setting. Speech therapy is not covered when used to improve speech skills that have not fully developed, except when speech is not fully developed in children (under age 19) due to an underlying disease or malformation that prevented speech development. Speech therapy is not covered when intended to maintain speech communication and is not restorative in nature. Occupational therapy is limited to services provided only for purposes of enabling a patient to perform the activities of daily living after an illness or injury.

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

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

Multiple outpatient services provided on the same day constitute one day.

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

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

The following are specifically excluded from chiropractic care services:

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

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

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

Note: Cigna does not have a network of acupuncturists. The Participant may use any licensed or certified practitioner. See the Schedules of Benefits for limitations on the number of visits and amount of reimbursement. The Participant may be required by the acupuncturist to pay at the time of service and then submit the claim to Cigna at the address on the reverse of the Participant's ID card.

(13) Delivery of medical, health-related and behavioral consultations and services via secure telecommunications technologies that shall include video capability, including telephones and internet, when delivered through a medical or behavioral telehealth provider.

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

(1) Room and board in a semi-private room (or private room when Medically Necessary and Cigna approved), including confinement in an intensive care unit.
(2) Inpatient skilled nursing care is available when admission to a facility is authorized by the Participant's PCP and/or Cigna. Cigna does not cover custodial confinements.
(3) Blood transfusion services, blood and blood products;
(4) Drugs, medications, biologicals, fluids and chemotherapy;
(5) Hospital ancillary services including but not limited to, use of operating room, and related facilities; anesthesia and associated services, radiology and other diagnostic and therapeutic services; general nursing services; inhalation therapy; radiation therapy; special diets; dressings and casts; and other services which are customarily provided in acute care Hospitals.
(6) Newborn care, including routine well baby charges.
(7) Physician services.

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

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

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

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

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

F. Emergency Services. In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest Hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral from your PCP for Emergency Services. If you require specialty care or a Hospital admission, your Physician and Cigna will coordinate and handle the necessary authorizations for care or hospitalization.

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

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

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

Home Health Services are provided only if Cigna has determined that the home is a Medically Appropriate and cost-effective setting and has authorized such services for the Participant in advance. If the Participant is a minor or an adult who is dependent upon others for non-skilled care and/or Custodial Care (e.g. bathing, eating, toileting, etc.), home health services will only be provided during times when there is a family member or caregiver present in the home to meet any non-skilled and/or Custodial services.

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

H. Hospice Care Services. Hospice Care Services charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:

(1) by a Hospice Facility for Bed and Board and Services and Supplies;
(2) by a Hospice Facility for services provided on an outpatient basis;
(3) by a Physician for professional services;
(4) by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
(5) for pain relief treatment, including drugs, medicines and medical supplies;
(6) by an Other Health Care Facility for:
    a. part-time or intermittent nursing care by or under the supervision of a Nurse;
    b. part-time or intermittent services of an Other Health Care Professional;
(7) physical, occupational and speech therapy;
(8) medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

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

(1) 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;
(2) for any period when you or your Dependent is not under the care of a Physician;
(3) for services or supplies not listed in the Hospice Care Program;
(4) for any curative or life-prolonging procedures;
(5) to the extent that any other benefits are payable for those expenses under the policy;
(6) for services or supplies that are primarily to aid you or your Dependent in daily living.

I. Transplant Services. Charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

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 Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are covered only on plans that have Out-Of-Network level benefits.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation (refer to Transplant Travel Services), hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services. Charges made for non-taxable travel expenses incurred by a Participant in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation and lodging are available only for a Participant if a Participant is the recipient of a preapproved 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 of the following: 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); and lodging while at, or traveling to and from the transplant site.

In addition to a Participant's coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany the Participant. 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 who is at least 18 years of age. The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when a Participant is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available when a Participant is a donor.

J. Medical Pharmaceuticals. The plan covers charges made for Medical Pharmaceuticals that are administered in an Inpatient setting, Outpatient setting, Physician's office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug first.

The Cigna Business Decision Team determines whether utilization management requirements or other coverage conditions should apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. When considering a Medical Pharmaceutical for a coverage status, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

K. Mental Health and Substance Use Disorder 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 in Mental Health. Substance Use Disorder 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 Use Disorder.

Inpatient Mental Health Services are provided by a Hospital while a Participant is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services. Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological

and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which 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, while a Participant is not Confined in a Hospital, and is provided in an individual, group or Mental Health Partial Hospitalization or Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which 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.

Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

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 in accordance with the laws of the appropriate, legally authorized agency. 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 Use Disorder Rehabilitation Services. Services provided for rehabilitation, while a Participant is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Residential Treatment services.

Substance Use Disorder 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 Use Disorder conditions.

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; 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 Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorder Rehabilitation Services. Services provided for the diagnosis and treatment of Substance Use Disorder or addiction to alcohol and/or drugs, while a Participant is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program. Substance Use Disorder Partial Hospitalization Services are rendered no less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency. 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 Use Disorder 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.

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

- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.

- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- 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.

L. Clinical Trials

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

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

(2) either

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or
- the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

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

The clinical trial must meet the following requirements:

The study or investigation must:

(1) be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;

(2) be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

(3) involve a drug trial that is exempt from having such an investigational new drug application.

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

(1) services required solely for the provision of the investigational drug, item, device or service;

(2) services required for the clinically appropriate monitoring of the investigational drug, item, device, or service;

(3) services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and

(4) reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

(1) the investigational drug, device, item, or service, itself; or

(2) items and services that are provided solely to satisfy data collection and analysis needs, and that are not used in the direct clinical management of the patient.

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

(1) there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or

(2) the clinical trial is conducted outside the individual's state of residence.

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

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

Definitions:

1. **Preferred Drug Formulary**. A list of prescription medications approved by the Cigna Pharmacy & Therapeutics (P&T) Committee for inclusion in the pharmacy benefit. The Preferred Drug Formulary is subject to change upon review by the P&T Committee.
2. **Preferred Brand Name Drug.** A branded Prescription Drug that has been designated by the Cigna P&T Committee as a Preferred Brand on the Preferred Drug Formulary. Preferred Brand designation is based on safety, effectiveness and cost.
3. **Generic Prescription Drug.** A medication that meets all United States Food and Drug Administration (FDA) standards and has the same active ingredients and the same potency as the originally invented product. The generic is generally less expensive than the alternative Non-Preferred Brand Name drug.
4. **Non-Preferred Brand Name Drugs.** A branded Prescription Drug that has been designated by the Cigna P&T Committee as a Non-Preferred Brand on the Drug Formulary. Non-Preferred Brand drugs include drugs that (1) have a U.S. Food and Drug Administration (FDA) A-rated and/or P&T Committee approved generic equivalent; (2) were reviewed by the P&T Committee and found not to have a significant therapeutic advantage over preferred brands; and (3) are usually not recommended as first-line therapy and have alternative treatment modalities. Medications newly approved by the FDA will be classified as Non-Preferred until they are reviewed by the Cigna Pharmacy & Therapeutics P&T Committee. All drugs newly approved by the FDA are designated as Non-Formulary Prescription Drugs until the P&T Committee evaluates the prescription drug clinically and considers whether it may be placed on the formulary. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.
5. **Mail Order Prescription Drug Program.** A Prescription Drug benefit feature that allows certain drugs designated by the Cigna P&T Committee to be filled up to a 90-day supply through a Participating Mail Order Pharmacy for the treatment of an ongoing medical condition. Drugs included in the Mail Order Prescription Drug Program are subject to change upon review by the P&T Committee.
6. **Maintenance Prescriptions.** Maintenance Prescription Drugs are those drugs which have been designated by the Cigna P&T Committee to be filled up to a 90-day supply through a Participating Mail Order Pharmacy for the treatment of an ongoing medical condition (such as hypertension or diabetes). Many drugs are included within this designation, but not all medications prescribed for ongoing conditions are included.
7. **Retail Prescriptions filled at Participating Pharmacies** are limited to a 30-day supply.

Covered Prescription Expenses

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

Limitations

In the event you or your Dependent insist on a more expensive Brand Drug where a Generic Drug is available, you will be financially responsible for the amount by which the cost of the Brand Drug exceeds the cost of the Generic Drug, plus any required Generic Drug Copayment and/or Coinsurance. In this case, the amount by which the cost of the Brand Drug exceeds the cost of the Generic Drug will not apply to your Deductible, if any, or Out of Pocket Maximum. However, in the event your Physician determines that the Generic Drug is not an acceptable alternative for you (and indicates Dispensed as Written on the Prescription Order or Refill), you will only be responsible for payment of the appropriate Brand Drug Coinsurance and/or Copayment after satisfying your Deductible, if any.

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

Prior Authorization Requirements

Coverage for certain Prescription Drugs prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization is required, your Physician may call or

complete the appropriate from Cigna is to determine whether the Prescription Drug is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug. Cigna, or its Review Organization, will not review claims for excluded Prescription Drugs or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drugs that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from Cigna before the Prescription Drug is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug. You will need to pay for the Prescription Drug at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug. The length of the authorization may depend on the diagnosis and the Prescription Drug. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.
If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the Prescription Drug should be covered.

Step Therapy
Certain Prescription Drugs are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drugs you are required to try a different Prescription Drug(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug is subject to step therapy requirements at the website shown on your ID card or by calling Cigna member services at the telephone number on your ID card.

Supply Limits
Benefits for Prescription Drugs are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug up to the stated supply limit.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling Cigna member services at the telephone number on your ID card.

Specialty Prescription Drugs
Benefits are provided for Specialty Prescription Drugs. If you require Specialty Prescription Drugs, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drugs.

Designated Pharmacies
If you require certain Prescription Drugs, including, but not limited to, Specialty Prescription Drugs, Cigna may direct you to a Designated Pharmacy with whom Cigna has an arrangement to provide those Prescription Drugs. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug from a Designated Pharmacy, you may not receive coverage for the Prescription Drug or be subject to the non-Network Pharmacy Benefit, if any, for that Prescription Drug. Refer to The Schedule for further information.

New Prescription Drugs
The Cigna Business Decision Team may or may not place a New Prescription Drug on the Prescription Drug List tier upon its market entry. The Business Decision Team will use reasonable efforts to make a tier placement decision for

a New Prescription Drug within six months of its market availability. The Business Decision Team's tier placement decision shall be based on consideration of, without limitation, the P&T Committee's clinical review of the New Prescription Drug and economic factors. If a New Prescription Drug not listed on the Prescription Drug List is approved by Cigna or its Review Organization as Medically Necessary in the interim, the New Prescription Drug shall be covered at the applicable coverage tier as set forth in The Schedule.

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

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

The amount you or your Dependent pays for any excluded Prescription Drug or other product or service will not be included in calculating any applicable plan Out-of-Pocket Maximum. You are responsible for paying 100% of the cost (the amount the Pharmacy charges you) for any excluded Prescription Drug or other product, and any negotiated Prescription Drug Charge will not be available to you.

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

Exclusions
Coverage exclusions listed under the "Benefit Exclusions and Exclusions and Limitations" sections also apply to benefits for Prescription Drugs. In addition, the exclusions listed below apply to benefits for Prescription Drugs. When an exclusion or limitation applies to only certain Prescription Drugs, you can access the internet through the website shown on your ID card or Cigna call member services at the telephone number on your ID card for information on which Prescription Drugs are excluded.

- coverage for Prescription Drugs for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.
- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drugs dispensed outside the jurisdiction of the United States, except as required for emergency or Urgent Care treatment.
- Prescription Drugs which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drugs furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- Prescription and non-prescription supplies other than supplies covered as Prescription Drugs.
- vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- medications used for cosmetic purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth, or medications used to control perspiration and fade cream products.
- Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.
- Prescription Drugs used for the treatment of infertility.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.
- any ingredient(s) in a compounded Prescription Drugs that has not been approved by the U.S. Food and Drug Administration (FDA).

- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug.
- certain Prescription Drugs that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- smoking cessation medications except those required by federal law to be covered as Preventive Care Medications.
- certain Prescription Drugs that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug that was previously excluded under this provision may be reinstated at any time.
- medications that are experimental or investigational or unproven as described under the "Exclusion and Limitations" section.

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

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

Purchase or rental of durable medical equipment that is ordered or prescribed by a Physician and provided by a vendor approved by the 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 that result from a Participant's misuse are the Participant's responsibility. Durable medical equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of illness or injury; are appropriate for use in the home; and are not disposable. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative, as determined by Cigna. Such equipment includes, but is not limited to, crutches, hospital beds, wheel chairs, dialysis machines, glucometers, and hearing aids. Also covered under this benefit: Jobst and TED stockings when ordered by a Physician and approved by Cigna.

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

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

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

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

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

Prostheses/Prosthetic Appliances and Devices

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

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

Orthoses and Orthotic Devices

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

(1) 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.

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

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

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

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

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

5. EXCLUSIONS AND LIMITATIONS

A. Exclusions.

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

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

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

   If Cigna provides services to a Participant who is covered by one of these programs, Cigna is entitled to reimbursement from the Participant or, if applicable, from that program for the value of such services at reasonable charges. See Sections 10 and11. The Participant agrees to actively seek to establish his or her rights to benefits from the sources noted above. If the Participant refuses or fails to establish his or her rights to these benefits, Cigna will not be responsible for the cost of treatment. If the Participant has recovered the value of Covered Services from one of these programs, the Participant is required to pay Cigna the amount recovered.
(8) Health care services for any accidents, injuries or illnesses, an act or omission of a person or organization, other than the Participant, for which benefits, settlements, awards or damages are received or payable (or could reasonably be expected to be received or payable if a claim were made) under any federal, state, county or municipal workers' compensation, employer's liability or occupational disease laws or personal injury settlement.
(9) Benefits payable as a result of injuries giving rise to third-party claims. See Section 10.
(10) Intentional home deliveries of infants, and all charges related to the delivery.
(11) Services, treatments and supplies for which no charge is normally made and/or are not Medically Necessary.
(12) Services relating to any injury or sickness resulting from war or any act of war (declared or undeclared), or in the armed forces of any country if the Participant is currently in active duty and the injury or sickness is covered by any government plan.
(13) Services not specifically described in the Health Benefits Booklet as Covered Services.
(14) Services, treatments and supplies received from any person in a Participant's immediate family or services that are self-administered.
(15) Services and supplies related to a non-covered service.
(16) The cost of any service connected with hospitalization when a Participant remains in the Hospital after continued hospitalization is no longer Medically Necessary as determined by Cigna.
(17) Court-ordered treatment for mental health and substance use disorder conditions and/or health services will be excluded if Cigna determines that court-ordered treatment is not Medically Necessary.
(18) Educational testing or therapy, as determined by Cigna.
(19) Dental implants for any purpose.

(20) Air conditioners, air filters, heaters, humidifiers, and other equipment that adjusts or regulates the interior environment, even if ordered by a Participating Provider.
(21) Foot care that is not Medically Necessary for treatment of a covered medical condition. Not Medically Necessary foot care services include, but are not limited to, care for corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints relating to the feet, toe nail trimming and supportive devices for feet, including corrective shoes.
(22) Homemaker services, such as meals, housekeeping and personal comfort items.
(23) Non-medical counseling services such as marriage and family therapy, sex therapy, hypnotherapy, assertiveness training, recreational, sleep, music, religious therapies and other forms of non-medical counseling, as determined by Cigna.
(24) Physical examinations, immunizations and all other medical services required for travel, insurance, employment or by other third parties.
(25) Rehabilitation services primarily intended to improve the level of physical functioning for purposes of enhanced job, athletic, or recreational performance including, but not limited to, work hardening programs, back schools, and programs of general physical conditioning.
(26) Services and costs relating to the biological mother of an adopted child, if the biological mother is not a Participant, and any services and costs relating to surrogate parenting.
(27) Cosmetic Services.
(28) Fertility services including, but not limited to,
- In vitro (test tube) fertilization, Gamete Intra-Fallopian Transfer (GIFT) and Zygote Intra-Fallopian Transfer (ZIFT), including all fertility-related treatment for these procedures.
- Reversal of voluntarily-induced sterility.
- Sperm preservation, purchase of donor sperm and any related processing costs.
- Infertility drugs.

(29) Therapies.
Occupational, speech, physical therapy treatment, cardiac rehabilitation and chiropractic care which is long-term, or which is in excess of the coverage provided in this Health Benefits Booklet.
(30) Vision.
- Any surgery to correct near/far sightedness, stigmatism and similar conditions.
- Vision Therapy (eye exercise therapy).

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

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

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

(2) **Orthognathic Surgery** to correct a severe facial deformity or disfigurement that orthodontics alone cannot correct will be covered, provided that
- The deformity or disfigurement is accompanied by a documented, clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement, or
- The orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease, or
- The orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

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

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

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

The following are excluded from coverage:

- Services including, but not limited to, dental treatment of the teeth, gums or structures directly supporting the teeth, crowns, caps, plates, bridges, dental x-rays, fillings, other artificial appliances, periodontal surgery, root canals, orthodontics, dental implants for any condition, casts, splints and services for dental malocclusion for any condition.
- Temporomandibular Joint (TMJ) disorders, except that Cigna will cover the initial consultation to include x-ray and single arthrogram to determine if a Participant has TMJ. Treatment for specific TMJ disorders may be covered on a case-by-case basis if further testing yields a more specific diagnosis. Medically Necessary surgery may be covered; however, appliances and orthodontic treatments are specifically excluded as a covered benefit.
- Soft palate reconstruction (veloplasty) to correct speech impediments.

(4) **Weight Control/Obesity.** Surgical treatment of clinically severe obesity, as defined by the body mass index (BMI) parameters of the National Heart, Lung and Blood Institute guidelines, is covered if the services are demonstrated through peer-reviewed medical literature and scientifically based guidelines to be safe and effective for treatment of the condition and these services are approved by Cigna. Medical and surgical services to alter appearance or physical changes that are the result of surgery performed for clinically severe obesity are excluded. Weight loss programs or treatments include anti-obesity products, anorexiants, diet pills, appetite suppressants (anorectics) and food products for weight control/obesity are not covered even if they are prescribed, supervised or recommended by a Physician.

(5) **Duplicate Coverage.** If a Participant holds two or more group plans, benefits under the non-Cigna plan shall be coordinated with benefits provided under this Agreement to avoid duplicate coverage. See Coordination of Benefits, Section 11.

6. ELIGIBILITY AND ENROLLMENT

A. Eligibility

(1) **Subscribers.** An Employee who meets all of the conditions for eligibility set by the employer and SCHOOLCARE is eligible to enroll. Employees must apply during an Open Enrollment Period or within 30 days after first meeting the employer's eligibility requirements.

(2) **Family Dependents.** To be eligible as a family Dependent, a person must be either:

(a.) The legal spouse of the Subscriber; or

(b.) The Subscriber's partner in a valid New Hampshire marriage or in a civil union/marriage recognized by the state of New Hampshire; or

(c.) A Dependent child of the Subscriber (or of the spouse). This child must be:

(i.) Under 26 years of age; or

(ii.) Any individual 26 or more years of age and continuously incapable of self-sustaining support because of a mental or physical handicap which existed prior to attaining age 26, provided that the disabled Dependent was covered by Employer's plan at the time such coverage would have ended, and there has been no lapse of coverage. You must submit proof of the child's condition and dependence to Cigna within 30 days after the date the child ceases to qualify as a Dependent under subsection (i), above. Cigna may, from time to time, during the next two years require proof of the continuation of

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

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

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

Court-Ordered Enrollment. Children covered pursuant to a court order will be subject to the same requirements and limits as any other family Dependent. In the event that expenses on behalf of a child covered pursuant to the terms of a court order are submitted for reimbursement by the child, the custodial parent or legal guardian, if such expenses are for Covered Services pursuant to the terms of this Health Benefits Booklet, Cigna shall make payment directly to the child, custodial parent or legal guardian.

(3) Subscribers may be asked to give written proof of eligibility of Dependents.

(4) Grandchildren of Subscribers are not eligible for coverage unless they meet the eligibility criteria for a Dependent.

(5) Military Personnel. Persons on active duty service in the Armed Forces are not eligible for coverage or benefits under the **SCHOOLCARE** plan.

(6) Domestic Partners (applicable if coverage is offered by your Employer). Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan when Medicare coverage is due to age. Therefore, when Medicare coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and Cigna is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer Rules explained above will apply.

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

(1) **Initial Eligibility.** When an Eligible Employee and his/her family Dependents initially become eligible for health coverage, if the Eligible Employee elects such coverage within 30 days.

(2) **Application.** During the Open Enrollment Period, Employees and their family Dependents who meet the requirements of Section 6.A. may enroll in **SCHOOLCARE** if they submit complete Enrollment Applications. Participants will complete such Enrollment Applications or other forms as Cigna and **SCHOOLCARE** may require. Participants represent that all information provided is true and complete. The type of membership, e.g., individual or family, is determined by the number of individuals to be covered as Subscriber and family Dependents.

(3) **Special Enrollment.** If the Subscriber is declining enrollment for himself or herself or for a Dependent because of other health insurance coverage, the Subscriber may in the future be able to enroll himself or herself or Dependents in **SCHOOLCARE**, provided the Subscriber requests enrollment within 30 days after the other health insurance coverage ends. In addition, if a new Dependent is being added as a result of marriage, birth, adoption, or placement for adoption, the Subscriber may be able to enroll himself, herself and any dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption. If so enrolled, the effective date of coverage will be the day of the event creating eligibility. If you do not enroll within 30 days of the event, the next opportunity for you and any eligible Dependents to enroll will be during the next Open Enrollment Period.

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

- are no longer eligible for the other coverage for any reason (including separation, divorce or death of the Subscriber); or
- lost the other coverage because an employer or plan sponsor failed to pay required premium or fees; or
- completed continuation of other coverage as provided under federal or state law; or
- lost public or private coverage as a result of termination of employment or eligibility; or

- requests enrollment within 30 days after termination of such health coverage; or
- was ordered by a court to provide health coverage for an ex-spouse or minor child under a covered employer's plan and request for enrollment is made within 30 days after issuance of such court order; or
- is employed by an employer that offers multiple health coverages and the person elects a different plan during an open enrollment period.

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

(5) **Effective Dates of Coverage.** Subject to the receipt and acceptance by **SCHOOLCARE** of the applicable premium, the Participant's Enrollment Application and the provisions of this Health Benefits Booklet, coverage shall become effective on the following dates:
- Except for Open Enrollment Periods, persons who meet the requirements of this Section for Participants shall have coverage effective as of the day such requirements are satisfied; or
- Coverage of newborn children shall become effective at birth for a period of 30 days from the date of birth. For coverage to continue beyond the initial 30 days, the Subscriber must enroll the newborn child before the 30th day following birth.

(6) **Membership Changes.** Employees must notify their employer and **SCHOOLCARE** of any Participants to be added or removed because of a Qualifying Event. All changes must be submitted in writing. Additions and/or deletions of Dependents must be made within 30 days of the following Qualifying Events:
- Marriage and/or divorce
- Birth and/or death
- Adoption
- Addition of stepchildren
- Permanent legal custody
- Reinstatement of civilian status from active military personnel
- Dependent over age 26, loss of coverage due to:
  - Cease to be Subscriber's Dependent as defined in Section 2.
  - Loss of other coverage due to termination of employment, termination of other coverage by someone other than the Dependent, the death of a spouse or divorce.

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

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

Qualified Medical Child Support Order. A Qualified Medical Child Support Order is a judgment, decree, or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:
- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy.

(8) **Hospital or other Institutional Confinement.** If a Subscriber or Dependent is confined to a hospital or other institution on the date that he or she becomes eligible for coverage, that Participant may enroll on the first day of eligibility and receive Covered Services, provided you notify Cigna HealthCare within two days, or as soon as reasonably possible thereafter, of such confinement. When you become a Participant, you agree to permit Cigna HealthCare to assume direct coordination of your health care. If the Participant fails to notify Cigna HealthCare of this confinement, refuses to permit Cigna HealthCare to coordinate care, or refuses to be transferred to the care of a Participating Provider or Hospital when Cigna HealthCare determines it is Medically Appropriate, SCHOOLCARE will not be obligated to pay for any medical or Hospital expenses that are related to your hospitalization following the first two days after your coverage begins.

(9) **Thirty-Day Retroactivity Limit.** SCHOOLCARE and Cigna do not permit a Subscriber to add, delete or change Membership more than 30 days after the event, which led to the requested change. Applications must be received by SCHOOLCARE and Cigna within 30 days after the Qualifying Event. Otherwise, the next opportunity for you and any eligible Dependent(s) to enroll will be during the next Open Enrollment Period.

(10) **Full and Accurate Completion of Enrollment Application.** Each Subscriber must fully and accurately complete the Enrollment Application. False, incomplete or misrepresented information provided in any Enrollment Application may, at SCHOOLCARE's sole discretion, cause the coverage to be null and void from its inception.

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

7. PAYMENT FOR COVERAGE

A. **Premiums.** Only Participants for whom the required Premium has been received by the Coalition shall be entitled to Covered Services under this Health Benefits Booklet, and then only for the period for which Premium is received.

B. **Subscriber Contributions.** The Subscriber is responsible for making any contributions toward the Premium required by the employer.

C. **Copays and Coinsurance.** Participants are responsible for paying Copays and Coinsurance as provided in this Health Benefits Booklet, any endorsements or riders and the Schedule of Benefits. Copays should be paid at the time the Covered Service is received.

D. **Deductibles.** Participants are responsible for paying for Covered Services up to the Deductible amount, if any. Please review the Schedules of Benefits to determine if any Deductible applies.

8. TERM AND TERMINATION

A. Term. This Health Benefits Booklet will continue in effect for one year from its effective date and from year to year thereafter subject to the termination provisions in Section 8.B. and any endorsements or riders.

B. Termination. Coverage under this Health Benefits Booklet may be terminated under the circumstances listed below:

(1) **Termination of the Agreement between the Coalition and Cigna.** Under the terms of the agreement between Cigna and the New Hampshire School Health Care Coalition, a Participant's coverage will end at midnight on the last day the agreement remains in effect.

(2) **Termination of the Agreement between the Coalition and the Employer.** A Participant's coverage will end at midnight on the last day the agreement remains in effect. Failure by the employer to notify Participants of termination of the agreement shall not cause coverage to be continued beyond the effective date of termination.

(3) **Termination of Participant Coverage.**

- For nonpayment of Premium by the employer to the Coalition on behalf of the Subscriber and Dependents.

- Membership ends on the date when the Participant is no longer eligible for coverage as a Subscriber or Dependent.
- For Cause:
  - Coverage may be terminated for misrepresentation on the Enrollment Application.
  - If a Participant permits another person to use their Identification Card, Cigna or the Coalition may reclaim the Identification Card and terminate membership.
  - Failure to cooperate in Coordination of Benefits or Right of Recovery under Sections 10 and 11.
  - If a Participant uses their Identification Card to obtain benefits for which he or she is not eligible.
  - If a Participant engages in conduct that disrupts or interferes with Cigna or Coalition operations.
  - Other failure by a Participant to comply with the terms and conditions of this Health Benefits Booklet, including any endorsements or riders attached hereto.

C. Effect of Termination. No benefits will be provided under this Health Benefits Booklet for services rendered after the date that coverage would otherwise terminate, including services rendered in connection with an injury or illness that commences prior to the effective date of termination.

D. Reinstatement. If a Participant's coverage is terminated for any reason, and that Participant then applies for a reinstatement of such coverage at any time other than a regularly scheduled Open Enrollment Period, the Coalition and Cigna may, in its sole discretion, choose to reinstate the Participant subject to such terms and conditions as the Coalition and Cigna may specify.

9. CONTINUATION OF COVERAGE

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

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

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

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

(1) 18 months; or

(2) 29 months in the case of a Participant who is determined under Title II or XVI of the Social Security Act to have been disabled within the first 60 days of the date the Participant becomes ineligible for continued participation in the **SCHOOLCARE** benefit program; or

(3) 36 months in the case of:
- the death of the covered Subscriber;
- the divorce or the legal separation of the covered Subscriber from his or her spouse;
- the covered Subscriber becoming entitled to benefits under Title XVIII of the Social Security Act, or the covered Participant's becoming entitled to benefits under Title XVIII of the Social Security Act within the 18-month continuation period in subparagraph (1); or
- a Dependent child ceasing to be a Dependent child; or

(4) When the surviving spouse, divorced spouse or legally separated spouse of a Subscriber is age 55 or older, in the case of the death of the Subscriber, or the divorce or the legal separation of the Subscriber from the Subscriber's spouse, then the extension period shall be continued until the surviving spouse, divorced spouse or legally separated spouse becomes eligible for participation in another employer-based group plan or becomes eligible for Medicare.

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

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

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

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

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

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

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

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

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

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

of the first 18 months of Continuation Coverage. The qualified beneficiary must also notify **SCHOOLCARE** within 60 days of any final disability determination, and within 30 days of any determination that the individual is no longer disabled.

10. SUBROGATION, REIMBURSEMENT AND RIGHT OF RECOVERY

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

A. Such benefits shall be subrogated to all of the Participant's rights of recovery against any person or entity to the extent of the benefits provided. The Participant shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Participant shall do nothing after loss to prejudice such rights. The Participant hereby agrees to cooperate with the New Hampshire School Healthcare Coalition (the "Coalition"), Cigna or any representatives of the Coalition or Cigna in completing such forms and in giving such information as the Coalition, Cigna or its representatives deem necessary to fully investigate the incident and prosecute its claim.

B. The Participant (or any attorney, agent or trustee on the Participant's behalf) shall reimburse **SCHOOLCARE** from the proceeds of any recovery in a Personal Injury Claim from any third party, whether by settlement, judgment, or otherwise, for benefits paid by **SCHOOLCARE** to or on behalf of the Participant. **SCHOOLCARE**'s share of any recovery shall not be reduced because the Participant has not received the full damages claimed unless **SCHOOLCARE** agrees in writing to such a reduction. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph A, but only to the extent of the benefits provided to the Participant by the **SCHOOLCARE** program.

C. The Participant agrees to grant, and hereby grants, to the Coalition and Cigna (acting on behalf of **SCHOOLCARE**) an equitable lien on the proceeds of any recovery in a Personal Injury Claim from any third party, whether by settlement, judgment or otherwise, intended for, payable to, or received by the Participant or any attorney, agent or trustee on the Participant's behalf. The Participant hereby consents to said equitable lien and agrees to take whatever steps are necessary to assist the Coalition or Cigna in securing and perfecting said lien. The Participant agrees that said lien shall constitute a charge upon and a property interest in the proceeds of any recovery in a Personal Injury Claim and the Participant and his/her representatives agree to hold the proceeds of any Personal Injury Claim recovery in trust for the benefit of **SCHOOLCARE** and Cigna to the extent of any benefits paid on behalf of the Participant.

D. The Participant agrees to assign, and hereby assigns, to the Coalition and Cigna (acting on behalf of **SCHOOLCARE**) the proceeds of any recovery in a Personal Injury Claim from any third party, whether by settlement, judgment or otherwise, intended for, payable to, or received by the Participant or any attorney, agent or trustee on the Participant's behalf in an amount equal to the benefits paid to or on behalf of the Participant. This assignment is and shall be binding on any attorney who represents the Participant (whether or not an agent of the Participant) and on any insurance company or other financially responsible party against whom a Participant may have a claim, provided said attorney, insurance company or other party has been notified by the Coalition, **SCHOOLCARE**, Cigna or its agents of this assignment.

E. The foregoing subrogation and reimbursement rights, equitable lien, and assignment provisions apply to any recoveries made by the Participant as a result of a Personal Injury Claim, including but not limited to the following:

(1) Payments made directly by the third-party tortfeasor, or any insurance company on behalf of the third-party tortfeasor, or any other payments on behalf of the third-party tortfeasor.
(2) Any payments or settlements or judgment or arbitration awards paid by any insurance company under the uninsured or underinsured motorist coverage of any insurance policy, whether on behalf of a Participant or other person.
(3) Any other payments, from any source, designed or intended to compensate a Participant for injuries sustained as the result of negligence or alleged negligence or any intentional act of a third party.
(4) Any workers' compensation award or settlement.
(5) Any recovery made pursuant to no-fault insurance.
(6) Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.

F. No adult Participant hereunder may assign any rights that he or she may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult Participant without the prior, written consent of the Coalition, SCHOOLCARE or Cigna. SCHOOLCARE's right to recover (whether by subrogation, reimbursement or assignment) shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.

G. No Participant shall make any settlement that specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by SCHOOLCARE or Cigna.

H. SCHOOLCARE's foregoing rights of recovery shall not be defeated or reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat SCHOOLCARE's recovery rights by allocating the proceeds of a Personal Injury Claim exclusively to non-medical expense damages.

I. No Participant hereunder shall incur any expenses on behalf of SCHOOLCARE in pursuit of SCHOOLCARE's rights hereunder; specifically, no court costs or attorneys' fees may be deducted from SCHOOLCARE or Cigna's recovery without the prior, written consent of the Coalition, SCHOOLCARE or Cigna. SCHOOLCARE's rights hereunder shall not be defeated by any so-called "Fund Doctrine," or "Common Fund Doctrine," or "Attorney's Fund Doctrine."

J. SCHOOLCARE and Cigna shall be entitled to recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.

K. The benefits under the SCHOOLCARE program are secondary to any coverage under no-fault or similar insurance.

L. In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the Coalition, SCHOOLCARE or Cigna shall be entitled to recover any costs incurred in enforcing the terms hereof, including but not limited to attorney's fees, litigation, court costs, and other expenses.

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

11.COORDINATION OF BENEFITS (COB)

A. Applicability.

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

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

B. Definitions.

(1) Other Coverage is any of the following that provides benefits or services for medical care or treatment (including dental):

- Group insurance or group-type coverage, whether insured or self-insured. This includes prepayment, group practice or individual practice coverage, but not student accident or student accident and health coverage, for which the student or parent pays the entire premium; or

- A closed panel plan that provides health benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits received from providers outside the panel, except in cases of emergency; or
- Coverage under Medicare and other governmental benefits as permitted by law, except Medicaid and Medicare supplemental polices; or
- Medical benefits coverage of group, group-type, and individual automobile policies. This includes "no fault: and traditional "fault" type contracts, which will be considered primary for any automobile accident-related medical expenses. Uninsured motorist insurance and automobile medical payment benefits shall be considered part of any automobile insurance.

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

(2) Primary Plan is the Plan that determines and provides or pays its benefits first, without taking into consideration the existence of any other Plan.

(3) Secondary Plan is the Plan that determines and may reduce its benefits after taking into consideration the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover the Reasonable Cash Value of any services it provided to you from the Primary Plan.

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

(4) Allowable Expense means a necessary, Reasonable and Customary Charge for a Covered Service, when the expense is covered at least in part by one or more Plans covering the person for whom the claim is made.
When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service rendered will be considered both an Allowable Expense and benefit paid.
Examples of expenses or services that are not an Allowable Expense include, but are not limited to, the following:
- An expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private hospital room and no Plan provides coverage for more than the semi-private room, the difference in cost between the private and semi-private room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of Reasonable and Customary fees, any amount in excess of the highest Reasonable and Customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of Reasonable and Customary fees, and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- When benefits are reduced under a Primary Plan because a Participant does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those relating to pre-certification of admissions and services, and preferred provider arrangements.

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

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

C. Order of Benefit Determination Rules.

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

(2) **Rules. SCHOOLCARE** will determine the order of benefits using the first of the following rules which applies:
- Subscriber: The Plan that covers you as a Subscriber or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan. If you are covered as a Subscriber under two

Plans, the benefits of the Plan that covered you longer are determined before those of the Plan which covered you for a shorter period of time.

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

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

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

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

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

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

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

G. Right of Recovery.
If the amount of the payments made by SCHOOLCARE is more than it should have paid under this COB provision, it may recover the excess from one or more of the following:
(1) From any person to, or for whom, or with respect to whom such services or payments were made;
(2) Insurance companies, health care plans, or

(3) Other organizations.

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

12. CLAIMS PROCEDURES

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

13. APPEAL PROCEDURES

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you" or "your" or "Participant" also refers to a representative or provider designated by you to act on your behalf; unless otherwise noted. "We" refers to Cigna, the claims administrator for the **SCHOOLCARE** Program.

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

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call the toll-free number on your ID card, explanation of benefits, or claim form and explain your concern to one of our Customer Service representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

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

Internal Appeals 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 us at the toll-free number on your ID card, explanation of benefits, or claim form.

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.

We will respond in writing with a decision within 30 calendar days after we receive an appeal for a required pre-service or concurrent care coverage determination or a post-service Medical Necessity determination. We will respond within 60 calendar days after we receive an appeal for any other post-service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

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

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves no authorization of an admission or continuing inpatient Hospital stay.

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

When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

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 the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate an external review. Cigna and your benefit plan will abide by the decision of the IRO.

To request a review, you must notify the Appeals Coordinator within 4 months of your receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render an opinion within 45 days.

When requested, and if 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 yet been discharged from a facility, the external review shall be completed within 72 hours.

Notice of Benefit Determination on Appeal

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

The decision of the IRO is binding on SCHOOLCARE, the New Hampshire School Health Care Coalition, and Cigna. The decision is binding on you as well, except that it does not prevent you from pursuing any other claim or remedy you may have under federal or state law. However, the Participant agrees that other legal remedies may only be pursued after all appropriate appeal procedures have been exhausted.

Relevant Information

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

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

Cigna HealthCare's Confidentiality Policies*

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

What Types of Information Do We Receive?

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

How Do We Protect Confidential Information?

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

1. We have established a Cigna HealthCare privacy program office, which is responsible for monitoring our compliance with confidentiality policies, and for educating the organization on this important topic.
2. Whenever possible, we provide only aggregate information that does not identify any individual. If we need to share individually identifiable information, we have policies that protect confidentiality.

3. Our employees may not disclose information to other employees except when it is needed to conduct Cigna HealthCare business.
4. We require a written agreement from companies and organizations, including plan sponsors, who receive confidential information from us. These companies and organizations agree that they will use any individually identifiable information only to administer the benefits plan in accordance with applicable laws.
5. Sometimes we require a plan participant's written authorization before we disclose confidential information. For example, a request from a research organization or from a plan participant's attorney would require an authorization signed by the plan participant. If the request were for information about a minor or an adult who was unable to exercise rational judgment or to give informed consent, we would require an authorization from the plan participant's parent or legal guardian.
6. We protect the confidentiality of information for former plan participants, just as we do for current plan participants.

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

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

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

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

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

How Can Plan Participants Access Their Confidential Information?

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

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

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

15. SCHOOLCARE NOTICE OF PRIVACY PRACTICES

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

Protected Health Information (PHI) is information, including demographic information, that may identify you and that relates to health care services provided to you, the payment for health care services provided to you, or your physical or

mental health condition, in the past, present or future. This Notice of Privacy Practices (the "Notice") describes how **SCHOOLCARE** may use and disclose your PHI. It also describes your rights to access and control your PHI.

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

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

PERMITTED USES AND DISCLOSURES

Treatment, Payment and Health Care Operations

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

1. Treatment. Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. **SCHOOLCARE** does not provide treatment.

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

Other Uses and Disclosures Allowed Without Authorization

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

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

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

OTHER USES AND DISCLOSURES

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

YOUR RIGHTS IN RELATION TO PROTECTED HEALTH INFORMATION

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

Right to Request Restrictions on Uses and Disclosures

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

Right to Receive Confidential Communications

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

Right to Access Your Protected Health Information

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

Right to Amend Protected Health Information

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

Right to Receive an Accounting of Disclosures

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

Right to Receive a Paper Copy of this Notice

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

COMPLAINTS

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

PRIVACY CONTACT

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

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

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

15. FEDERAL REQUIREMENTS

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

Notice of Provider Directory/Network

Notice Regarding Provider Directories and Provider Networks

A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

Notice Regarding Pharmacy Directories and Pharmacy Networks

A list of network pharmacies is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of pharmacies affiliated or contracted with Cigna or an organization contracting on its behalf.

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

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

Qualified Medical Child Support Order Defined

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

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

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

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

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

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

- Acquiring a new Dependent. If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage.
- Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP). If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- Loss of eligibility for other coverage (excluding continuation coverage). If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
    - divorce or legal separation;
    - cessation of Dependent status (such as reaching the limiting age);
    - death of the Employee;
    - termination of employment;
    - reduction in work hours to below the minimum required for eligibility;
    - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
    - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
    - the other plan no longer offers any benefits to a class of similarly situated individuals.
- Termination of Employer contributions (excluding continuation coverage). If a current or former Employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- Exhaustion of COBRA or other continuation coverage. Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the Employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an Employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP). If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

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

Effect of Section 125 Tax Regulations on This Plan

Your Employer may choose to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage elections
Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed

- if you meet Special Enrollment criteria and enroll as described in the Special Enrollment section; or
- if your Employer agrees, and you meet the criteria shown in the following Sections B through H and enroll for or change coverage within the time period established by your Employer.

B. Change of status
A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court order
A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid eligibility/entitlement
The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in cost of coverage
If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.
When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in coverage of spouse or Dependent under another employer's plan
You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

G. Reduction in work hours
If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in a Qualified Health Plan (QHP)
The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

Eligibility for Coverage for Adopted Children
Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.
If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.
The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Coverage for Maternity Hospital Stay
Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact Cigna.

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

Group Plan Coverage Instead of Medicaid
If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)
Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave
Your health insurance will be continued during a leave of absence if:
- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave
Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.
You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.
Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)
The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage
For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.
For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:
You may continue benefits by paying the required premium to your Employer, until the earliest of the following:
- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Reinstatement of Benefits (applicable to all coverages)
If your coverage ends during the leave of absence because you do not elect USERRA at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.
You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.
If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

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

Procedures Regarding Medical Necessity Determinations
In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on a preservice, concurrent, or post service basis, as described below:
Certain services require prior authorization in order to be covered. The booklet describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described below, in the booklet, and in your provider's network participation documents as applicable.
When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the booklet, in your provider's network participation documents as applicable, and in the determination notices.

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

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna will defer to the determination of the treating health care professional regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

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

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

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

Post service Determinations
When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative

within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

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

Notice of Adverse Determination
Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, (if applicable); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; a description of any available internal appeal and/or external review process(es); information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

16. MISCELLANEOUS PROVISIONS

A. **Major Disaster or Epidemic.** In the event of major disaster, epidemic, war or other circumstances beyond the control of Cigna, Cigna will make a good faith effort to provide or arrange for Covered Services. However, Cigna will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

B. **Administrative Policies Relating to this Health Benefits Booklet.** The Coalition, Cigna, and Cigna HealthCare may adopt reasonable policies, procedures, rules and interpretations that promote orderly administration of the SCHOOLCARE benefits program, as described in this Health Benefits booklet.

C. **Entire Health Benefits Booklet.** This Health Benefits Booklet, along with any endorsements or riders attached hereto, the Schedules of Benefits and Enrollment Application represent the entire agreement between the Subscriber, the Coalition and Cigna. No employee or agent of the Coalition, Cigna or any of its Participating Providers, other than written amendment by the Chief Executive Officer of Cigna and the Coalition, may bind the Coalition and Cigna to any other terms, payment or coverage.

D. **Identification Cards.** Identification Cards are for identification only. Possession of a Cigna HealthCare Identification card does not confer any right to receive Covered Benefits and Services. To be entitled to receive Covered Benefits and Services, the cardholder must be a Participant for whom Premium payments have been paid. If a Participant permits the use of his/her Identification Card by any other person, Cigna or the Coalition may reclaim the card and terminate all SCHOOLCARE benefits and the rights of such Subscriber and other Participants of his/her family as described in this Health Benefits Booklet after providing notice under Section 8. In the case of loss or theft of a membership Identification Card, such occurrence must be reported immediately to the Coalition and Cigna. By using the Identification card to obtain Covered Services, the Participant agrees to all the terms and conditions on the Enrollment Application and this Health Benefits Booklet, including allowing Cigna access to medical records for utilization management and quality purposes, and to coordinate benefits.

E. **Notice to a Subscriber**. Official notices from the Coalition, Cigna or Cigna HealthCare will be delivered to the latest name and address listed for the Subscriber and/or Dependents as noted on the Enrollment Application provided to the Coalition. Subscribers are responsible for notifying in writing their employer and the Coalition of any changes in name and address.

F. **Time Limitation of Actions.** No action at law shall be brought against Cigna, Cigna HealthCare, the Coalition or SCHOOLCARE for failing to provide Covered Services, unless: (1) it is brought within one year from the date that the original claim was filed; and (2) the Participant has availed himself/herself of all rights under the Appeal Procedures, as outlined in Section 13.

G. **No Implied Waiver.** Failure by SCHOOLCARE, the Coalition or Cigna to enforce any rights conferred by this Health Benefits Booklet shall not be construed as a waiver of any rights in the future.

H. **Primary Care Physician/Provider Organization.** In the benefit plans offered by the Coalition and Cigna, the Participant will be encouraged to select a Primary Care Physician. The PCP will provide most of the Participant's care and will coordinate the Participant's care when Prior Approval is Medically Necessary.

I. **Non-Participating Providers.** No services are covered when Referrals are made to Non-Participating Providers, unless specifically authorized in writing by Cigna.

J. **Change of Primary Care Physician.** A Participant may change his/her PCP by contacting Cigna, either by calling Member Services or at the personalized mycigna.com website.

K. **Successors and Assignability.** The provisions of the SCHOOLCARE benefits program as described in this Health Benefits Booklet shall be binding upon and shall inure to the benefit of the successors and assigns of the Coalition and Cigna, but shall not be assignable by any Participant.

L. **Clerical Error.** No clerical error on the part of the Coalition or Cigna shall operate to defeat any of the rights, privileges or benefits of any Participant.

M. **Section Headings.** Section headings are for convenience only and are not intended to aid in the interpretation of any benefit.

N. **Cross-References.** Cross-references are provided for convenience of the reader and are not intended as exclusive references to all applicable provisions.

O. **Severability.** If any term, provision, covenant or condition of this Health Benefits Booklet, (including any endorsements or riders attached hereto) is held by a court of competent jurisdiction to be invalid, void, or unenforceable, all remaining provisions shall continue in full force and effect and shall not otherwise be impaired or invalidated.

First Amendment to the
New Hampshire School Health Care Coalition
Health Benefits Booklet

WHEREAS, the New Hampshire School Health Care Coalition (the "Plan Sponsor") sponsors the SCHOOLCARE Health Benefits Plan, effective July 1, 2019 (the "Plan"); and

WHEREAS, Section 16c of the Plan reserves to the Plan Sponsor the right to amend the Plan; and

WHEREAS, the Plan Sponsor wishes to amend the Plan with respect to clarifying definitions and expanded infertility coverage as approved by the Membership Council on November 5, 2019.

NOW THEREFORE, the Plan is amended effective July 1, 2020 as follows:

Section 2. Definitions, added as follows:

Charges. The actual billed charges; except when Cigna has contracted directly or indirectly for a different amount including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers of such services and/or supplies.

Covered Expenses. The expenses incurred by a person while covered under this plan for the charges listed below for preventive care services and services or supplies that are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. Any applicable Copay, Coinsurance, Deductible or limits apply.

As determined by Cigna, Covered Expenses may also include all charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below.

Network Pharmacy. A retail or home delivery Pharmacy that has entered into an agreement with Cigna or an entity contracting on Cigna's behalf to provide Prescription Drug Products to plan enrollees, agreed to accept specified reimbursement rates for dispensing Prescription Drug Products, and been designated as a Network Pharmacy for the purposes of coverage under this plan.

Section 3. Schedules of Benefits, the following provisions apply to In-Network Medical Benefits:

Certain Specialty Prescription Drugs are only covered when dispensed by a Home Delivery Pharmacy.

Choice Fund - Health Reimbursement Account (HRA). The Coalition may establish an HRA ($1,000 Individual/$2,000 Family), that can be used to pay out-of-pocket Covered Services during the Contract Year.

Prescription Drugs – Patient Assurance Program (PAP). PAP waives the deductible and reduces the amount you owe for certain diabetic insulin medication to a $25 copay/coinsurance. Additionally, any amount you pay for certain diabetic insulin medications counts toward meeting your out-of-pocket maximum.

Infertility and Conception Services offered through WINFertility provides coverage at the same level as other benefits (Physician, Facility and Professional Services) on your Plan:

- Testing and treatment services performed in connection with an underlying medical condition.
- Testing performed specifically to determine the cause of infertility.
- Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).
- Treatment and/or procedure performed to enable conception with or without an infertility condition.
- Artificial Insemination/Intrauterine Insemination, regardless of an infertility condition, In-vitro, GIFT, ZIFT, etc.
- Fertility preservation [when an infertility condition is imminent].
- Access to reproductive services for the purpose of pre-implantation genetic diagnosis (PGD) and embryo selection when parent(s), though fertile, are known carriers of genes associated with birth defects.

Maximums apply:

Artificial Insemination – 3 cycles
In Vitro – 3 retrieval cycles, 3 transfer cycles
Cryopreserved Reproductive Material Storage – 1 year

Section 4. Benefits and Services, the following is added:

Q. Infertility and Conception Services. See the Schedules of Benefits for other information regarding the Contract Year benefit allowance and Coinsurance requirements.

Charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed, charges made for intrauterine insemination/artificial insemination services related to enabling conception regardless of an infertility diagnosis; access to harvesting of sperm and oocytes for the purposes of cryopreservation and short term storage of sperm, oocytes, and embryos; access to reproductive services for the purpose of pre-implantation genetic diagnosis (PGD) and embryo selection when parent(s), though fertile, are known carriers of genes associated with birth defects. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician; cryopreservation, storage, and thawing of [sperm] and [eggs] and [embryos]; 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. Treatment is managed by WINFertility and limited to the number of cycles shown in the Schedule.

Infertility is defined as:

- the inability of opposite-sex partners to achieve conception after at least one year of unprotected intercourse;
- the inability of opposite-sex partners to achieve conception after six months of unprotected intercourse, when the female partner trying to conceive is age 35 or older;
- the inability of a woman, with or without an opposite-sex partner, to achieve conception after at least six trials of medically supervised artificial insemination over a one-year period; and
- the inability of a woman, with or without an opposite-sex partner, to achieve conception after at least three trials of medically supervised artificial insemination over a six- month period of time, when the female partner trying to conceive is age 35 or older.

This benefit includes diagnosis and treatment of both male and female infertility.

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;
- pre-implantation genetic screening (PGS) and genetic screening of parents/donors beyond what is covered as by the medical plan;
- any experimental, investigational or unproven infertility procedures or therapies.

IN WITNESS WHEREOF, the Plan Sponsor has executed this First Amendment as of this 10th day of August, 2020.

New Hampshire School Health Care Coalition

By: Lisa J. Duquette

Name: Lisa J. Duquette

Title: Executive Director

Second Amendment to the
New Hampshire School Health Care Coalition
Health Benefits Booklet

WHEREAS, the New Hampshire School Health Care Coalition (the "Plan Sponsor") sponsors the SCHOOLCARE Health Benefits Plan, effective July 1, 2019 (the "Plan"); and

WHEREAS, Section 16c of the Plan reserves to the Plan Sponsor the right to amend the Plan; and

WHEREAS, the Plan Sponsor wishes to amend the Plan with respect to clarifying coverages.

NOW THEREFORE, the Plan is amended effective July 1, 2021 as follows:

Section 1. Introduction – Important Information, added as follows:

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) - Non-Quantitative Treatment Limitations (NQTLs). Federal MHPAEA regulations provide that a plan cannot impose a Non-Quantitative Treatment Limitation (NQTL) on mental health or substance use disorder (MH/SUD) benefits in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, those used in applying the NQTL to medical/surgical benefits in the same classification of benefits as written and in operation under the terms of the plan.

Non-Quantitative Treatment Limitations (NQTLs) include:

- Medical management standards limiting or excluding benefits based on Medical Necessity or whether the treatment is experimental or investigative;
- Prescription drug formulary design;
- Network admission standards;
- Methods for determining in-network and out-of-network provider reimbursement rates;
- Step therapy a/k/a fail-first requirements; and
- Exclusions and/or restrictions based on geographic location, facility type or provider specialty.

A description of your plan's NQTL methodologies and processes applied to medical/surgical benefits and MH/SUD benefits is available for review covered persons at www.cigna.com/sp. To determine which document applies to your plan, select the relevant health plan product; medical management model (inpatient only or inpatient and outpatient) which can be located in this booklet immediately following The Schedule; and pharmacy coverage.

Section 3. Schedules of Benefits, the following addition applies to In-Network Medical Benefits:

Transgender Services coverage at the same level as other benefits (Physician, Facility and Professional Services) on your Plan.

Section 4. Benefits and Services, the following is added:

R. Transgender Services. See the Schedules of Benefits for other information regarding the Contract Year benefit allowance and Coinsurance requirements.

Coverage is provided for services related to gender transition, including gender reassignment surgery. Coverage when applicable includes behavioral counseling, hormone therapy, genital reconstructive surgical procedures, and initial mastectomy or breast reduction.

IN WITNESS WHEREOF, the Plan Sponsor has executed this Second Amendment as of this 9th day of August, 2021.

New Hampshire School Health Care Coalition

By: Lisa J. Duquette

Name: Lisa J. Duquette

Title: Executive Director

Third Amendment to the
New Hampshire School Health Care Coalition
Health Benefits Booklet

WHEREAS, the New Hampshire School Health Care Coalition (the "Plan Sponsor") sponsors the SCHOOLCARE Health Benefits Plan, effective July 1, 2019 (the "Plan"); and

WHEREAS, Section 16c of the Plan reserves to the Plan Sponsor the right to amend the Plan; and

WHEREAS, the Plan Sponsor wishes to amend the Plan with respect to clarifying coverages.

NOW THEREFORE, the Plan is amended effective July 1, 2022 as follows:

Section 1. Introduction – Important Information, added as follows:

SaveOnSP Specialty Program. As a participant in the plan, you may opt to enroll in the SaveOnSP program, in which certain pharmaceutical manufacturers may provide assistance for certain costs associated with specific Specialty Prescription Drug Products that are used to treat various conditions, such as: hepatitis C, multiple sclerosis, psoriasis, inflammatory bowel disease, rheumatoid arthritis, oncology and various others (specific drugs and manufacturer programs may vary from time to time).

If you have enrolled and are receiving medications under this program, manufacturer assistance will reduce or eliminate your Out-of-Pocket cost. If you choose not to sign up with SaveOnSP, your prescription drug cost-share (the amount you pay) for the medications listed, will be as indicated at the link below, which may be amended from time to time. The Specialty Prescription Drug Products included in this program are considered non-Essential Health Benefits as set forth in the Patient Protection and Affordable Care Act of 2010 (PPACA) and any amount you pay will not count towards your Deductible or Out-of-Pocket Maximums, if any. To determine if your medication qualifies for the SaveOnSP program, you can go to www.saveonsp.com/Cigna or contact SaveOnSP at 800-683-1074.

IN WITNESS WHEREOF, the Plan Sponsor has executed this Third Amendment as of this 9th day of August, 2022.

New Hampshire School Health Care Coalition

By: Lisa J. Duquette

Name: Lisa J. Duquette

Title: Executive Director

Fourth Amendment to the
New Hampshire School Health Care Coalition
Health Benefits Booklet

WHEREAS, the New Hampshire School Health Care Coalition (the "Plan Sponsor") sponsors the SCHOOLCARE Health Benefits Plan, effective July 1, 2019 (the "Plan"); and

WHEREAS, Section 16c of the Plan reserves to the Plan Sponsor the right to amend the Plan; and

WHEREAS, the Plan Sponsor wishes to amend the Plan with respect to compliance with the Consolidated Appropriations Act – No Surprise Bill and clarifying coverages.

NOW THEREFORE, the Plan is amended effective July 1, 2023 as follows:

Section 2. Definitions replaced or added as follows:

Emergency Medical Condition. A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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, with respect to 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. With respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or emergency department, as are required to Stabilize the patient.

Maximum Reimbursable Charge – Medical. Does not apply to Emergency Services. Determined based on the lesser of: the provider's normal charge for a similar service or supply; the amount agreed to by the Out-of-Network provider and Cigna; or a percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable reimbursement for the same or similar service within the geographic market. The percentage used to determine the Maximum Reimbursable Charge can be obtained by contacting Cigna Member Services/Customer Service. In some cases, a Medicare based schedule will not be 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; the amount agreed to by the Out-of-Network provider and Cigna; or the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna.

Stabilize. With respect to an Emergency Medical Condition, to provide medical treatment as necessary to assure that no material deterioration of the condition is likely if the individual is transferred from a facility, or, with respect to a pregnant woman who is having contractions, to deliver.

Section 3. Schedule of Benefits, the following replaced or added as follows:

Choice Fund – Health Reimbursement Account (HRA) [SCHOOLCARE Yellow Open Access Schedule of Benefits ONLY]
The SCHOOLCARE Yellow Open Access with Choice Fund Plan includes an embedded Choice Fund HRA in the amount of $1,000 Individual/$2,000 Family. It can be used to pay the first portion of eligible out-of-pocket expenses during the Contract Year. The Subscriber must take the online health assessment at myCigna annually during the sixty (60) day period beginning June 1st or, if newly enrolling, within sixty (60) days of the effective date. Any balance in the Choice Fund HRA on June 30th rolls over to the following Contract Year for any Subscriber continuing to be enrolled with SCHOOLCARE in a Yellow with Choice Fund, Yellow or Orange Open Access Plan. The annual rollover cannot exceed $2,000 Individual/$4,000 Family.

Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-Participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.
3. The allowable amount used to determine the Plan's benefit payment when Out-of-Network Emergency Services result in an inpatient admission is the median amount negotiated with In-Network facilities.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

Air Ambulance

Subject to any plan coinsurance and plan deductible.

IN WITNESS WHEREOF, the Plan Sponsor has executed this Fourth Amendment as of this 20th day of July, 2023.

New Hampshire School Health Care Coalition

By: Lisa J. Duquette

Name: Lisa J. Duquette

Title: Executive Director

This booklet describes the benefits, limitations and exclusions for the SchoolCare Health Benefit Plans. It replaces all similar documents previously issued to you by SchoolCare or Cigna. Verify with your employer which SchoolCare plans are available to you before completing an enrollment application.

SchoolCare

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