Cigna Benefit Solutions for:

City of Coral Gables

RFP# 2024-020

Electronic Submission

July 2024

A Proposal for:

Medical, Pharmacy, Behavioral Health, and EAP Coverage

Provided by:

Listed below are the legal names of the companies submitting this response to the City of Coral Gables Request for Proposal. In this proposal, the name "Cigna" and other service marks, or division/trade names, may be used to refer to these companies and/or the products and services offered by them or their affiliates. All affiliated Cigna companies and operating subsidiaries are indirectly wholly owned subsidiaries of The Cigna Group*, a publicly traded corporation.

Cigna Health and Life Insurance Company (CHLIC)
Evernorth Care Solutions, Inc.

*As of February 13, 2023, the name “Cigna Corporation” was changed to “The Cigna Group.” Any reference in this proposal to the “Cigna Corporation” is a reference to “The Cigna Group.”

City of Coral Gables

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CITY OF CORAL GABLES, FL

2800 SW 72nd Avenue, Miami, FL 33155
Finance Department / Procurement Division
Tel: 305-460-5102 / Fax: 305-261-1601

PROPOSER'S ACKNOWLEDGEMENT

RFP Title: **Group Medical Insurance Services**	**Electronic submittals must be received prior to 2:00 p.m., Friday July 26, 2024, via INFOR and will remain valid for 120 calendar days. Submittals received after the specified date and time will not be accepted.**
RFP No.: 2024-020 A cone of silence is in effect with respect to this RFP. The Cone of Silence prohibits certain communication between potential vendors and the City. For further information, please ref er to the City Code Section 2-1027 of the City of Coral Gables Procurement Code.	Contact: Neivy Garcia Title: Procurement Specialist Telephone:305-460-5121 Email:ngarcia2@coralgables.com contracts@coralgables.com

Proposer Name: (1) **Cigna Health and Life Insurance Company (CHLIC)** (2) **Evernorth Care Solutions, Inc.**	FEIN or SS Number: (1) **59-1031071** (2) **86-1465626**
Complete Mailing Address: (1) **900 Cottage Grove Road, Hartford, CT 06152**(2) **1 Express Way, St. Louis, MO 63121**	Telephone No.: (1) **860-226-6000** (2) **800-332-5455** Cellular No.: **N/A**
Indicate type of organization below: Corporation: **X** Partnership: __Individual: __Other:_	Fax No.: **N/A**
Bid Bond/Security Bond (if applicable) **N/A**	Email: **Kimberly.Funderburk@CignaHealthcare.com**

ATTENTION: THIS FORM ALONG WITH ALL REQUIRED RFP FORMS MUST BE COMPLETED, SIGNED (PREFERABLY IN BLUE INK), AND SUBMITTED WITH THE RESPONSE PRIOR TO THE SUBMITTAL DEADLINE. FAILURE TO DO SO MAY DEEM PROPOSER NON-RESPONSIVE.

THE PROPOSERCERTIFIES THATTHIS SUBMITTAL IS BASED UPON ALL CONDITIONS AS LISTED IN THE RFP DOCUMENTS AND THAT THE PROPOSER HAS MADE NO CHANGES IN THE RFP DOCUMENT AS RECEIVED. THE PROPOSER FURTHER AGREES IF THE RFP IS ACCEPTED, THE PROPOSER WILL EXECUTE AN APPROPRIATE AGREEMENT FOR THE PURPOSE OF ESTABLISHING A FORMAL CONTRACTUAL RELATIONSHIP BETWEENTHE PROPOSERANDTHE CITY OF CORAL GABLES FORTHE PERFORMANCE OF ALL REQUIREMENTS TO WHICH THIS RFP PERTAINS. FURTHER, BY SIGNING BELOW PREFERABLY IN **BLUE INK**, ALL RFP PAGES ARE ACKNOWLEDGED AND ACCEPTED AS WELL AS ANY SPECIAL INSTRUCTION SHEET(S) IF APPLICABLE. THE UNDERSIGNED HEREBY DECLARES (OR CERTIFIES) ACKNOWLEDGEMENT OF THESE REQUIREMENTS AND THAT HE/SHE IS AUTHORIZED TO BIND PERFORMANCE OF THIS RFP FOR THE ABOVE PROPOSER.

To the extent that the responses in this RFP are mutually agreed upon, Cigna agrees to be bound by that language; however, in the case of an insured arrangement, Cigna agrees to issue policies reflecting the agreed-upon specifications. The provisions of the insurance policy will supersede the RFP.

Kimberly L. Funderburk	Vice President of CHLIC and Authorized Signatory	7/10/24
Authorized Name and Signature	*Title*	*Date*

√SOLICITATION SUBMISSION CHECKLIST

Request for Proposals (RFP) No. 2024-020

COMPANY NAME: (Please Print): Cigna Healthcare
Phone: (860) 226-6000 Email: Dina.D'Angelo@CignaHealthcare,com

A response package numbered by page must be submitted ELECTRONICALLY via INFOR. Please provide the PAGE NUMBER of your solicitation response in the blanks provided as to where compliance information is located in your Submittal for each of the required submittal items listed below:

SUBMITTAL - SECTION I: TITLE PAGE, TABLE OF CONTENTS, REQUIRED FORMS, AND MINIMUM QUALIFICATION REQUIREMENTS.

1) Title Page: Show the RFP number and title, the name of your firm, address, telephone number, name of contact person, e-mail address, and date. **PAGE: Section I, Page 1**

2) Provide a Table of Contents in accordance with and in the same order as the respective "Sections" listed below. Clearly identify the material by section and page number. **PAGE: Section I, Page 2**

3) Fill out, sign, and submit the Proposer's Acknowledgement Form. **PAGE: Section I, Page 4**

4) Fill out and submit the Solicitation Submission Check List. **PAGE: Section I, Page 6**

5) Fill out, sign, notarize (as applicable), and submit the Proposer's Affidavit and Schedules A through H.

PAGE: Section I, Pages 9-18

6) Fill out, E-Verify Affidavit **PAGE: Section I, Page 19**

7) Minimum Qualification Requirements: submit detailed verifiable information affirmatively documenting compliance with the Minimum Qualifications Requirements shown in Section 3.

PAGE: Section I, Pages 20-63

8) Fill out, Lobbyist Registration & Oral Presentation Forms **PAGE: Section I, Pages 64-67**

SUBMITTAL - SECTION II: EXPERIENCE AND PROPOSER'S QUALIFICATIONS

(i) FOR PROPOSER:

1) Provide a complete history and description of your company, including, but not limited to, the number of years in business, size, number of employees, office location, copy of applicable licenses/certifications, credentials, capabilities, and capacity to meet the City's needs. **PAGE: Section II, Pages 68-84**

2) Describe the Proposer's relevant knowledge and experience in providing the services described in the "Scope of Services" to public sector agencies similar in size to the City of Coral Gables.

PAGE: Section II, Pages 85-89

3) Financial Strength Rating from AM Best, with a minimum of A-, XIV. **PAGE: Section II, Pages 90-92**

4) Qualifications, copy of applicable licenses/certifications and experience of all proposed key personnel. **PAGE: Section II, Pages 93-101**

SUBMITTAL - SECTION III: PROJECT APPROACH AND METHODOLOGY

1) Describe in detail your approach to performing the services solicited herein. Include detailed information, as applicable, which addresses, but need not be limited to: understanding of the RFP scope and requirements, implementation plan and communication with City staff and Consultants. Indicate how the Proposer intends to positively and innovatively work with the City in providing the services outlined in this RFP.
PAGE: Section III, Pages 102-101 & 190-197

2) Provide a detailed description of the service, including but not limited to:

   a. Proposer's Provider Network being utilized for the City of Coral Gables. Be sure to complete the Provider Network Section, Question 14 in Exhibit G Group Questionnaire which identifies the number of Providers, Facilities and Pharmacies by County. **PAGE: Section III, Page 158**

   b. Proposer's lack of restrictions or exclusions imposed. **PAGE: Section III, Page 168**

   c. Proposer's offering of an Online Benefit Enrollment system for the Open Enrollment process, along with the ability to include additional lines of coverage. **PAGE: Section III, Page 144**

   d. Proposer's ability to provide covered individuals access to company professionals to discuss benefit coverage issues, nurse help line and various health topics. **PAGE: Section III, Page 184 & 190-197**

   e. Identify wellness options and Proposer's overall commitment towards health/wellness activities.

   PAGE: Section III, Pages 163-166

3) Provide a comprehensive description of your proposed ability to duplicate existing coverage for employees, retirees and dependents. Additionally, providing alternate benefit options (as identified in the RFP) for future costs controls.

PAGE: Section III, Page 142

SUBMITTAL – SECTION IV: PAST PERFORMANCE AND REFERENCES

1) Using the required Attachment A - Reference Form, provide a minimum of three (3) references (but no more than five (5) for which Proposer has performed similar scope of services in the last five (5) years. **DO NOT include work/services performed for the City of Coral Gables or City employees as reference (*City related experience will be outlined in the request below*).** **PAGE Section IV, Pages 198-200**

2) List all contracts for which the Proposer as performed (past and present) as a PRIME for the City of Coral Gables. The City will review all contracts the Proposer has performed for the City. Any and all Proposer's performance records (satisfactory and unsatisfactory) will be utilized in the evaluation process regardless of the type of work performed for the city. **PAGE Section IV, Page 201**

3) Provide a list with contact information (Name of Agency, contact person, telephone number, email address) of all public sector clients in the last ten (10) years, and include if any, that have discontinued use of Proposer's services within the last two (2) years and indicate the reasons for the same. Additionally, please provide any documentation related to performance issues of the current or past contracts to include any non-performance reports or notices to cure. The list of projects shall include the name of the project, the value, date(s) of project, etc. The City reserves the right to contact any reference or current customer identified as part of the evaluation process. **PAGE Section IV, Pages 202-206**

4)

5) Please identify each incident within the last five (5) years where a civil, criminal, administrative, other similar proceeding was filed or is pending, if such proceeding arises from or is a dispute concerning the Proposer's rights, remedies or duties under a contract for the same or similar type services to be provided under this RFP (*See Affidavit D*). **PAGE Section IV, Page 207**

SUBMITTAL – SECTION V: PROPOSAL PRICE PROPOSAL

1) Provide pricing in INFOR for premiums being charged for employees, and dependents.

PAGE Confirmed provided in INFOR

2) Provide Proposer's Medical Trend history and the current factors being used by the company.

PAGE Section III, Page 159

3) Identify additional pricing (if any) for ancillary costs to be added to the program. **PAGE Section V, Page 234**

4) Describe Proposer's Cost Guarantees or rating caps that can be applied for future rating periods.

PAGE Section V, Pages 248-2453

5) Provide two (2) Alternate HMO plans with pricing for employees, employee plus spouse, employee plus child(ren), and employee plus family.. **PAGE Section V, Pages 235-247**

SUBMITTAL – SECTION VI: AGREEMENT COMMENTS/EXCEPTIONS

1) Please follow the instructions as outlined in Section 1.6 Agreement Execution. The acceptance of or any exceptions taken to the terms and conditions of the City's Agreement shall be considered a part of a Proposer's submittal and will be considered by the Evaluation Committee. **PAGE Section VI, Pages 253-255**

- - N O T I C E - -

BEFORE SUBMITTING YOUR RFP RESPONSE MAKE SURE YOU:

☑ 1. Carefully read and have a clear understanding of the RFP, including the Scope of Services and enclosed Professional Services Agreement (*draft*).

☑ 2. Carefully follow the Submission Requirements outlined in Section 6 of the RFP and ensure you have submitted all of the required information. DO NOT INCLUDE A COPY OF THE ORIGINAL SOLICITATION.

☑ 3. **Prepare and submit electronically via INFOR.**

☑ 4. Make sure your Response is submitted prior to the submittal deadline. **Late responses will not be accepted.**

FAILURE TO SUBMIT THIS CHECKLIST AND THE REQUESTED DOCUMENTATION MAY RENDER YOUR RESPONSE SUBMITTAL NON-RESPONSIVE AND CONSTITUTE GROUNDS FOR REJECTION. THIS PAGE IS TO BE RETURNED WITH YOUR RESPONSE PACKAGE.

ATTACHMENT B
PROPOSER'S AFFIDAVIT INCLUDING SCHEDULES A THROUGH H

PROPOSER'S AFFIDAVIT

SOLICITATION: RFP 2024- 020 Group Medical Insurance Services

SUBMITTED TO: City of Coral Gables
Procurement Division
2800 SW 72 Avenue
Miami, Florida 33155

The undersigned ac knowledges and understands the information contained in response to this solicitation and the referenced Schedules A through H shall be relied upon by Owner awarding the contract and such information is warranted by the Proposer to be true and correct. The discovery of any omission or misstatements that materially affects the Proposer's ability to perform under the contract shall be cause for the City to reject the solicitation submittal, and if necessary, terminate the award and/or contract. I further certify that the undersigned name(s) and official signatures of those persons are authorized as *(Owner, Partner, Officer, Representative or Agent of the Proposer that has submitted the attached Response).* Schedules A through H are subject to Local, State and Federal laws (as applicable); both criminal and civil.

- SCHEDULE A – STATEMENT OF CERTIFICATION
- SCHEDULE B – NON-COLLUSION AND CONTINGENT FEE AFFIDAVIT
- SCHEDULE C – DRUG-FREE STATEMENT
- SCHEDULE D – PROPOSER'S QUALIFICATION STATEMENT
- SCHEDULE E – CODE OF ETHICS, CONFLICT OF INTEREST, AND CONE OF SILENCE
- SCHEDULE F – AMERICANS WITH DISABILITIES ACT (ADA)
- SCHEDULE G – PUBLIC ENTITY CRIMES
- SCHEDULE H – ACKNOWLEDGEMENT OF ADDENDA

This affidavit is to be furnished to the City of Coral Gables with its RFP response. It is to be filled in, executed by the Proposer and notarized. If the response is made by a Corporation, then it should be executed by its Chief Officer. This document MUST be submitted with the response.

Kimberly L. Funderburk Kimberly L. Funderburk	**Vice President of Cigna Health and Life Insurance Company (CHLIC) and Authorized Signatory**	7/10/24
Authorized Name and Signature	Title	*Date*

STATE OF Georgia

COUNTY OF Fulton

On this 10th day of July, 2024, before me the undersigned Notary Public of the State of GA, personally appeared **Kimberly L. Funderburk**
(Name(s) of individual(s) who appeared before Notary

And whose name(s) is/are subscribes to within the instrument(s), and acknowledges it's execution.

Debby F. Vetter
NOTARY PUBLIC, STATE OF GA

Debby F Vetter
(Name of notary Public; Print, Stamp or Type as Commissioned.)

NOTARY PUBLIC
SEAL OF OFFICE:

Personally know to me, or Produced Identification:

Known to me
(Type of Identification Produced)

SCHEDULE "A" - CITY OF CORAL GABLES – STATEMENT OF CERTIFICATION

Neither I, nor the firm, hereby represented has:

a. employed or retained for a commission, percentage brokerage, contingent fee, or other consideration, any firm or person (other than a bona fide employee working solely for me or the Proposer) to solicit or secure this contract.

b. agreed, as an express or implied condition for obtaining this contract, to employ or retain the services of any firm or person in connection with carrying out the contract, or

c. paid, or agreed to pay, to any firm, organization or person (other than a bona fide employee working solely for me or the Proposer) any fee, contribution, donation or consideration of any kind for, or in connection with, procuring or carrying out the contract except as here expressly stated (if any):

Confirmed.

SCHEDULE "B" - CITY OF CORAL GABLES - NON-COLLUSION AND CONTINGENT FEE AFFIDAVIT

1. He/she is the **Vice President of CHLIC and Authorized Signatory**
(Owner, Partner, Officer, Representative or Agent)

of the Proposer that has submitted the attached response.

2. He/she is fully informed with respect to the preparation and contents of the attached response and of all pertinent circumstances respecting such response;

3. Said response is made without any connection or common interest in the profits with any other persons making any response to this solicitation. Said response is on our part in all respects fair and without collusion or fraud. No head of any department, any employee or any officer of the City of Coral Gables is directly or indirectly interested therein. If any relatives of Proposer's officers or employees are employed by the City, indicate name and relationship below.

Name: **Not Applicable** Relationship: _____

Name: **Not Applicable** Relationship: _____

4. No lobbyist or other Proposer is to be paid on a contingent or percentage fee basis in connection with the award of this Contract.

SCHEDULE "C" CITY OF CORAL GABLES – VENDOR DRUG-FREE STATEMENT

Preference may be given to vendors submitting a certification with their bid/proposal certifying they have a drug- free workplace in accordance with Section 287.087, Florida Statutes. This requirement affects all public entities of the State and becomes effective January 1, 1991. The special condition is as follows:

1. Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.

2. Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.

3. Give each employee engaged in providing the commodities or contractual services that are under solicitation a copy of the statement specified in subsection (1).

4. In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under solicitation, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.

5. Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available in the employee's community, by any employee who is so convicted.

6. Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section. As the person authorized to sign the statement, I certify that this form complies fully with the above requirements.

The company submitting this solicitation has established a Drug Free work place program in accordance with State Statute 287.087

SCHEDULE "D" CITY OF CORAL GABLES – PROPOSER'S QUALIFICATION STATEMENT

The undersigned declares the truth and correctness of all statements and all answers to questions made hereinafter:

GENERAL COMPANY INFORMATION:

Company Name: (1) Cigna Health and Life Insurance Company (2) Evernorth Care Solutions, Inc.

Address: 900 Cottage Grove Road / 1 Expressway (Street) Bloomfield / St. Louis (City) (1)CT (2) MO (State) (1) 06002 (2) 63111 (Zip Code)

Telephone No: 860 226-6000/800-332-5455 Fax No: ( ) Not applicable Email: N/A

How many years has your company been in business under its present name? (1)*14 Years (2) 6 years

Please note, Cigna Health and Life Insurance Company (CHLIC) was originally incorporated in Connecticut on May 2, 1963, as Orange State Life Insurance Company. After several transactions, it was acquired by Cigna Corporation through Connecticut General Life Insurance Company (CGLIC) on April 1, 2008. The company was renamed to CHLIC on March 5, 2010.

If Proposer is operating under Fictitious Name, submit evidence of compliance with Florida Fictitious Name Statue:

Not applicable

Under what former names has your company operated? : **CHLIC has operated under the following former names: Orange State Life Insurance Company, Home Life Financial Assurance Corporation, Anthem Health & Life Insurance Company and Alta Health & Life Insurance Company. Evernorth Care Solutions, Inc. has not operated under any other names.**

At what address was that company located? **120 Monument Circle, Indianapolis, IN 46204**

Is your Company Certified? Yes X No___ If Yes, **ATTACH COPY** of Certification.

Is your Company Licensed? Yes X No___ If Yes, **ATTACH COPY** of License

Has your company or its senior officers ever declared bankruptcy?

Yes_____No X If yes, explain:_____

LEGAL INFORMATION:

Please identify each incident ***within the last five (5) years*** where a civil, criminal, administrative, other similar proceeding was filed or is pending, if such proceeding arises from or is a dispute concerning the Proposer's rights, remedies or duties under a contract for the same or similar type services to be provided under this RFQ ***(A response is required. If applicable please indicate "none" or list specific information related to this question. Please be mindful that responses provided for this question will be independently verified)***:

Our business is a heavily regulated industry. We are subject to numerous regular inquiries and oversight by various state and federal authorities. When one of our companies is presented with regulatory inquiries, it is our policy to cooperate fully to resolve any issues. To the best of our

knowledge and belief, neither The Cigna Group, nor any of its principals, officers, or directors are involved in any federal, state, or other governmental investigation concerning criminal or quasi-criminal violations.

Please refer to Form 10-K and Form 10-Q for an updated description of material legal proceedings. These documents are available online: http://www.cigna.com/aboutus/sec-filings.

Has your company ever been debarred or suspended from doing business with any government entity?

Yes ___ No **X** If Yes, explain

SCHEDULE "E" CITY OF CORAL GABLES – CODE OF ETHICS, CONFLICT OF INTEREST, AND CONE OF SILENCE

THESE SECTIONS OF THE CITY CODE CAN BE FOUND ON THE CITY'S WEBSITE, UNDER GOVERNMENT, CITY DEPARTMENT, PROCUREMENT, PROCUREMENT CODE (CITY CODE CHAPTER 2 ARTICLE VIII); SEC 2-1023; SEC 2-606; AND SEC 2-1027, RESPECTIVELY.

IT IS HEREBY ACKNOWLEDGED THAT THE ABOVE NOTED SECTIONS OF THE CITY OF CORAL GABLES CITY CODE ARE TO BE ADHERED TO PURSUANT TO THIS SOLICITATION.

Confirmed.

SCHEDULE "F" CITY OF CORAL GABLES - AMERICANS WITH DISABILITIES ACT (ADA)
DISABILITY NONDISCRIMINATION STATEMENT

I understand that the above named firm, corporation or organization is in compliance with and agreed to continue to comply with, and assure that any sub-contractor, or third party contractor under this project complies with all applicable requirements of the laws listed below including, but not limited to, those provisions pertaining to employment, provision of programs and service, transportation, communications, access to facilities, renovations, and new construction.

The American with Disabilities Act of 1990 (ADA), Pub. L. 101-336, 104 Stat 327, 42 U.S.C. 12101,12213 and 47 U.S.C. Sections 225 and 661 including Title I, Employment; Title 11, Public Services; Title III, Public Accommodations and Services Operated by Private Entities; Title IV, Telecommunications; and Title V, Miscellaneous Provisions.

The Florida Americans with Disabilities Accessibility Implementation Act of 1993, Sections 5553.501-553.513, Florida Statutes

The Rehabilitation Act of 1973, 229 U.S.C. Section 794

The Federal Transit Act, as amended, 49 U.S.C. Section 1612

The Fair Housing Act as amended, 42 U.S.C. Section 3601-3631

Agreed, as applicable to the insurance products contemplated in this proposal.

SCHEDULE "G" CITY OF CORAL GABLES - STATEMENT PURSUANT TO SECTION 287.133 (3) (a), FLORIDA STATUTES, ON PUBLIC ENTITY CRIMES

1. I understand that a "public entity crime" as define in Paragraph 287.133(1)(g), **Florida Statutes**, means a violation of any state or federal law by a person with respect to and directly related to

the transaction of business with any public entity or with an agency or political subdivision of any other state or of the United States, including, but not limited to, any Proposal or contract for goods or services to be provided to any public entity or an agency or political subdivision of any other state or of the United States and involving antitrust, fraud, theft, bribery, collusion, racketeering, conspiracy, or material misrepresentation.

2. I understand that "convicted" or "conviction" as defined in Paragraph 287.133(1)(b), **Florida Statutes**, means a finding of guilt or a conviction of a public entity crime, with or without an adjudication of guilt, in any federal or state trial court of record relating to charges brought by indictment or information after July 1, 1989, as a result of a jury verdict, non-jury trial, or entry of a plea of guilty or nolo contendere.

3. I understand that an "affiliate" as defined in Paragraph 287.133(1)(a), **Florida Statutes**, means:

1. A predecessor or successor of a person convicted of a public entity crime; or 2. An entity under the control of any natural person who is active in the management of the entity and who has been convicted of a public entity crime. The term "affiliate" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in the management of an affiliate. The ownership by one person of shares constituting a controlling interest in another person, or a pooling of equipment or income among persons when not for fair market value under an arm's length agreement, shall be a prima facie case that one person controls another person. A person who knowingly enters into a joint venture with a person who has been convicted of a public entity crime in Florida during the preceding 36 months shall be considered an affiliate.

4. I understand that a "person" as defined in Paragraph 287.133(1)(e), **Florida Statutes**, means any natural person or entity organized under the laws of any state or of the United States with the legal power to enter into a binding contract and which Proposals or applies to Proposal on contracts for the provision of goods or services let by a public entity, or which otherwise transacts or applies to transact business with a public entity. The term "person" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in management of an entity.

5. Based on information and belief, the statement which I have marked below is true in relation to the entity submitting this sworn statement. **[Must indicate which statement below applies.]**

X Neither the entity submitting this sworn statement, nor any of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, nor any affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989.

__The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity subsequent to July 1, 1989.

____The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989. However, there has been subsequent proceeding before a Hearing Officer of the State of Florida, Division of Administrative Hearings and the Final Order entered by the Hearing Officer determined that it was not in the public interest to place the entity submitting this sworn statement on the convicted vendor list.

[Attach a copy of the final order]

I UNDERSTAND THAT THE SUBMISSION OF THIS FORM TO THE CONTRACTING OFFICER FOR THE PUBLIC ENTITY IS FOR THAT PUBLIC ENTITY ONLY AND, THAT THIS FORM IS VALID THROUGH DECEMBER 31 OF THE CALENDAR YEAR IN WHICH IT IS FILED. I ALSO UNDERSTAND THAT I AM REQUIRED TO INFORM THE PUBLIC ENTITY PRIOR TO ENTERING INTO A CONTRACT IN EXCESS OF THE THRESHOLD AMOUNT PROVIDED IN SECTION 287.017, FLORIDA STATUTES FOR CATEGORY TWO OF ANY CHANGE IN THE INFORMATION CONTAINED IN THIS FORM.

SCHEDULE "H" CITY OF CORAL GABLES - ACKNOWLEDGEMENT OF ADDENDA

1. The undersigned agrees, if this RFP is accepted, to enter in a Contract with the CITY to perform and furnish all work as specified or indicated in the RFP, any associated addendum and Contract Documents within the contract time indicated in the RFP and in accordance with the other terms and conditions of the solicitation and contract documents.

2. Acknowledgement is hereby made of the following Addenda, if any (identified by number) received since issuance of the Request for Proposal.

Addendum No. 1 Date 7/9/2024 Addendum No._____Date_____

Addendum No._____Date_____ Addendum No._____Date_____

Addendum No._____Date_____ Addendum No._____Date_____

Failure to adhere to changes communicated via any addendum may render your response non-responsive.

City of Coral Gables
Finance Department/Procurement Division

Employer E-Verify Affidavit

By executing this affidavit, the undersigned employer verifies its compliance with F.S. 448.095, stating affirmatively that the individual, firm or corporation has registered with and utilizes the federal work authorization program commonly known as E-Verify, or any subsequent replacement program, in accordance with the applicable provisions and deadlines established in F.S. 448.095 which prohibits the employment, contracting or sub-contracting with an unauthorized alien. The undersigned employer further confirms that it has obtained all necessary affidavits from its subcontractors, if applicable, in compliance with F.S. 448.095, and that such affidavits shall be provided to the City upon request. Failure to comply with the requirements of F.S. 448.095 may result in termination of the employer's contract with the City of Coral Gables. Finally, the undersigned employer hereby attests that its federal work authorization user identification number and date of authorization are as follows:

Cigna agrees to provide the City with E-verify verification for any subcontracted arrangements procured specifically to service the relationship between Cigna and the City.

1352298
Work Authorization User Identification Number

12/28/2018
Date of Authorization

I hereby declare under penalty of perjury that the foregoing is true and correct.

Executed on July 10, 2024 in Atlanta (city), GA (state).

Kimberly L. Funderburk
Signature of Authorized Officer or Agent

Kimberly L. Funderburk **Vice President of Cigna Health and Life Insurance Company and Authorized Signatory**
Printed Name and Title of Authorized Officer or Agent

SUBSCRIBED AND SWORN BEFORE ME

ON THIS THE 10th DAY OF July ,2024

Debby F. Vetter
NOTARY PUBLIC
My Commission Expires:
Nov. 16, 2026

(1) Be regularly engaged in the business of providing goods and/or services similar in scope and size as described in the "**Scope of Services"** for a minimum of five (5) years. Bidder's ability to demonstrate the minimum of five (5) years shall be verified through bidder's references provided.
Confirmed.

(2) Provide a **minimum** of three (3) references for similar engagements satisfactorily performed in the last five (5) years. **All references must outline the specific dates when the service(s) were provided and cover the full minimum number of years of experience as stated above**.
At least one (1) of the references' start date must cover the five (5) year period from the issuance of this solicitation.
Confirmed. Please refer to Sections I and IV of this proposal for the reference documents.

(3) Bidder must be licensed to do business as an insurance company in the State of Florida. Provide proof that you are registered or that an application to do business as an insurance company was submitted to the Florida Office of Insurance Regulation (FLOIR) and approval was granted. Please include the types of insurance you have the authority to underwrite and that your authority is current (has not expired). Requirement shall be verified thru submittal of current insurance business license; proof of approval and that underwriting authority is current from the FLOIR.
Confirmed. Please refer to Section I of this proposal for the licenses and FLOIR.

(4) Bidder or any Principal of the Bidder shall not have been party to any bankruptcy proceeding within the last five (5) years. Requirement shall be verified thru submittal of current D&B Report or alternate method of proving solvency within the last five (5) years.
Confirmed. Please refer to Section I for the D&B Reports.

(5) Provide active certificate/license to prove a minimum financial strength rating of "A-"or equivalent from AM Best.

Confirmed. Please see attached A.M. Best rating certificate for Cigna Health and Life Insurance Company (CHLIC).

The following represent the general qualification(s) required by the successful Proposer prior to final award or contract execution:

General Qualifications:

Provide proof of active status or documentation evidencing Proposer is currently seeking active status with the Florida Department of State, Division of Corporation.

Submittals: Current Florida Department of State, Division of Corporation certificate or equivalent document.

Confirmed. Please refer to Section I for the Sunbiz Registrations.

1. **Project Name/Location City of Naples**

   Contact Person Lori McCullers

   Contact Telephone No. (239) 213-1833

   Email Address: lmccullers@naplesgov.com

   Dates of Contract From: 10/1/2006 To: Current

   Project Description Medical, Pharmacy, Stop Loss, FSA, Dental, EAP

2. **Project Name/Location Palm Beach County Sheriff's Office**

   Contact Person Karen Thomas

   Contact Telephone No. (561) 688-3638

   Email Address: thomaskl@pbso.org

   Dates of Contract From: 1/1/2010 To: Current

   Project Description Medical, Pharmacy, Dental, EAP

3. **Project Name/Location City of Miami Beach**

   Contact Person Marvin Adams

   Contact Telephone No. (305) 670-7000 ext 26723

   Email Address: marvin.adams@miamibeachfl.gov

   Dates of Contract From: 10/1/2016 To: Current

   Project Description Medical, Pharmacy, Dental, EAP

D&B Finance Analytics

Printed By: Kate Gruevska

Date Printed: 06/20/2024

LIVE REPORT

CIGNA HEALTH AND LIFE INSURANCE COMPANY

Tradestyle(s): (SUBSIDIARY OF CONNECTICUT GENERAL LIFE INSURANCE COMPANY, BLOOMFIELD, CT) 1

ACTIVE HEADQUARTERS

D-U-N-S Number: 83-174-4102
Phone: +1 800 997 1654

Address: 900 Cottage Grove Rd, Bloomfield, CT, 06002, United States Of America
Endorsement: kate.gruevska@cigna.com

Summary

Currency: USD

KEY DATA ELEMENTS (Formerly: SCORE BAR)

KDE Name	Current Status	Details
PAYDEX®	80	Pays on time
Delinquency Score	89	Low to Moderate Risk of severe payment delinquency.
Failure Score	64	Moderate Risk of severe financial stress.
D&B Viability Rating	3 4 B Z	View More Details
Bankruptcy Found	N	
D&B Rating	ERN	Not Available.

ALL ACCOUNTS

Totals	Total Outstanding	Approved Credit Limit	Credit Limit Utilization	Total Past Due
-	-	-	-	-

Account Level Detail

Account Name	Total Outstanding	Approved Credit Limit	Credit Limit Utilization	Total Past Due

There are currently no account associated with this D-U-N-S.
Upload account or create an account to view summary.

ALL APPLICATIONS

Totals	Total Requested Amount	Total Credit Limit
-	-	-

Application Level Detail

Application Name	Application Status	Date Created	Date Decisioned	Requested Amount	Credit Limit

26

There are no applications associated with this D-U-N-S. Create an application to view summary.

COMPANY PROFILE

D-U-N-S
83-174-4102

Mailing Address
UNITED STATES

Age (Year Started)
28 Years (1996)

Legal Form
Unknown

Telephone
+1 800 997 1654

Named Principal
David Cordani , CEO-PRES

History Record
Clear

Present Control Succeeded
2008

Line of Business
Hospital/medical service plan

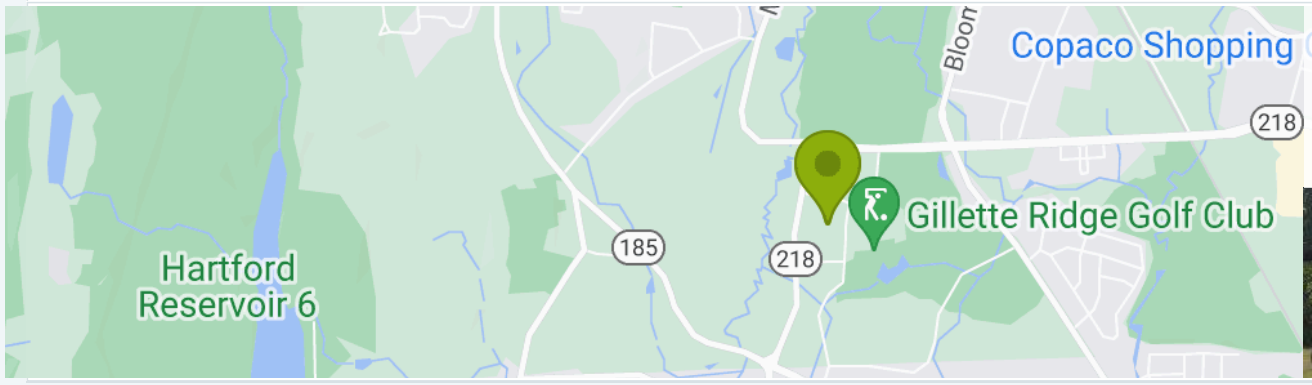
Date Incorporated
03/05/2010

SIC
6324

State of Incorporation
CONNECTICUT

NAICS
524114

Ownership
Not publicly traded



Street Address:
900 Cottage Grove Rd,
Bloomfield, CT, 06002,
United States Of America

OVERALL BUSINESS RISK

Dun & Bradstreet thinks...

HIGH	MODERATE-HIGH	MODERATE	LOW-MODERATE	LOW

Overall assessment of this organization over the next 12 months:	**Stable Condition**
Based on the predicted risk of business discontinuation:	**Likelihood-Of-Continued-Operations**
Based on the predicted risk of severely delinquent payments:	**Low Potential For Severely Delinquent Payments**

D&B MAX CREDIT RECOMMENDATION

MAXIMUM CREDIT RECOMMENDATION

22,500 (USD)

The recommended limit is based on a low probability of severe delinquency.

FAILURE SCORE (Formerly Financial Stress Score)

Company's Risk Level
MODERATE

Probability of failure over the next 12 months
0.16 %

64

High Risk (1) Low Risk (100)

Past 12 Months

Low Risk

High Risk

DELINQUENCY SCORE (Formerly Commercial Credit Score)

Company's Risk Level

LOW-MODERATE

Probability of delinquency over the next 12 months

1.68 %

89

High Risk (1) Low Risk (100)

Past 12 Months

Low Risk

High Risk

VIABILITY RATING SUMMARY

Viability Score

3

High Risk (9) Low Risk (1)

Data Depth Indicator

B

Descriptive (G) Predictive (A)

Portfolio Comparison

4

High Risk (9) Low Risk (1)

Financial Data	Unavailable
Trade Payments	
Company Size	
Years in Business	-

D&B PAYDEX®

80

High Risk (1) Low Risk (100)

0 pays on time

Past 24 Months

Low Risk

High Risk

D&B PAYDEX - 3 MONTHS

80

High Risk (1) Low Risk (100)

ON TERMS

PAYDEX® TREND CHART

SBRI ORIGINATION

No SBRI Origination Score data is currently available.

D&B SBFE SCORE

No D&B SBFE Score data is currently available.

D&B RATING

Employee Size

ERN : employees-na

Current Rating as of 07/02/2011

LEGAL EVENTS

Events	Occurrences	Last Filed
Bankruptcies	0	-
Judgements	0	-
Liens	1	11/15/2023
Suits	239	02/08/2024
UCC	664	02/20/2024

DETAILED TRADE RISK INSIGHT™

Days Beyond Terms

0 Days

3 Months

From Apr-24 to Jun-24

0

High Risk (120+) Low Risk (0)

Days Beyond Terms Past 3 months :

Low Risk:0 ; High Risk:120+

Dollar-weighted average of **2** payment experiences reported from **2** companies.

DETAILED TRADE RISK INSIGHT™ 13 MONTH TREND

Total Amount Current and Past Due -

FINANCIAL OVERVIEW - BALANCE SHEET

No Data Available

TRADE PAYMENTS

Highest Past Due:

0

Highest Now Owing	Total Trade Experiences	Largest High Credit
1,000	16	40,000

FINANCIAL OVERVIEW - PROFIT AND LOSS

No Data Available

OWNERSHIP

Subsidiaries	Branches	Total Members
4	3	528

This company is a Headquarters, Parent, Subsidiary.

	Immediate Parent	Global Ultimate	Domestic Ultimate
Name	Connecticut General Life Insurance Company	The Cigna Group	The Cigna Group
Country	United States	United States	United States
D-U-N-S	00-691-7082	08-116-1936	08-116-1936
Others	-	-	-

FINANCIAL OVERVIEW - KEY BUSINESS RATIOS

No Data Available

ALERTS

There are no alerts for this D-U-N-S Number.

NEWS

GENERAL INDUSTRY

Who are Connecticut's remote workers? New study details demographics, pay and more | The Hour | 06/20/2024

GENERAL INDUSTRY

Anesthetics Market 2024: Size, Share, Trends And Forecast To 2033 | Open PR | 05/27/2024

GENERAL INDUSTRY

GAMMA Investing LLC Has $710,000 Holdings in The Cigna Group (NYSE:CI) | Defense World - Companies | 06/20/2024

EARNINGS RELEASE, GENERAL INDUSTRY, FINANCIAL NEWS, MERGER AND ACQUISITION

The Cigna Group (NYSE:CI) Director Elder Granger Sells 547 Shares | Defense World - Companies | 06/20/2024

EARNINGS RELEASE, GENERAL INDUSTRY, FINANCIAL NEWS, MERGER AND ACQUISITION

The Cigna Group (NYSE:CI) Director Elder Granger Sells 547 Shares | MarketBeat | 06/20/2024

GENERAL INDUSTRY

Moody National Bank Trust Division Cuts Stock Holdings in The Cigna Group (NYSE:CI) | Defense World | 06/20/2024

GENERAL INDUSTRY

Moody National Bank Trust Division Sells 40 Shares of The Cigna Group (NYSE:CI) | ETF Daily News | 06/20/2024

GENERAL INDUSTRY

Express Scripts by Evernorth Members Paid Less for Prescriptions in 2023 Despite Drug Price Increases | Maryville Forum | 06/20/2024

GENERAL INDUSTRY

Trust Co. of Toledo NA OH Trims Stock Holdings in The Cigna Group (NYSE:CI) | Defense World - Companies | 06/20/2024

GENERAL INDUSTRY

Cigna group director sells shares worth over $181,000 By Investing.com | The Fifth Skill | 06/20/2024

COUNTRY/REGIONAL INSIGHT

United States Of America

Expectations of a first Fed rate cut are pushed back to Q4 amid continued strong US economic data - including surging job growth in May - and sticky inflation.

Risk Category

LOW

High Risk Low Risk

Available Reports

Country Insight Report (CIR)

Current Publication Date: 06/14/2024

Country Insight Snapshot (CIS)

Current Publication Date: 06/14/2024

STOCK PERFORMANCE

No stock performance data is available for this D-U-N-S Number.

The scores and ratings included in this report are designed as a tool to assist the user in making their own credit related decisions, and should be used as part of a balanced and complete assessment relying on the knowledge and expertise of the reader, and where appropriate on other information sources. The score and rating models are developed using statistical analysis in order to generate a prediction of future events. Dun & Bradstreet monitors the performance of thousands of businesses in order to identify characteristics common to specific business events. These characteristics are weighted by significance to form rules within its models that identify other businesses with similar characteristics in order to provide a score or rating.

Dun & Bradstreet's scores and ratings are not a statement of what will happen, but an indication of what is more likely to happen based on previous experience. Though Dun & Bradstreet uses extensive procedures to maintain the quality of its information, Dun & Bradstreet cannot guarantee that it is accurate, complete or timely, and this may affect the included scores and ratings. Your use of this report is subject to applicable law, and to the terms of your agreement with Dun & Bradstreet.

Risk Assessment

Currency: All figures shown in USD unless otherwise stated

D&B RISK ASSESSMENT

OVERALL BUSINESS RISK

HIGH	MODERATE-HIGH	MODERATE	LOW-MODERATE	LOW

Dun & Bradstreet thinks...

- Overall assessment of this organization over the next 12 months: **STABLE CONDITION**
- Based on the predicted risk of business discontinuation: **LIKELIHOOD-OF-CONTINUED-OPERATIONS**
- Based on the predicted risk of severely delinquent payments: **LOW POTENTIAL FOR SEVERELY DELINQUENT PAYMENTS**

MAXIMUM CREDIT RECOMMENDATION

22,500 (USD)

The recommended limit is based on a low probability of severe delinquency.

D&B VIABILITY RATING SUMMARY

The D&B Viability Rating uses D&B's proprietary analytics to compare the most predictive business risk indicators and deliver a highly reliable assessment of the probability that a company will go out of business, become dormant/inactive, or file for bankruptcy/insolvency within the next 12 months. The D&B Viability Rating is made up of 4 components:

Viability Score

Compared to All US Businesses within the D&B Database:

- Level of Risk:**Low Risk**
- Businesses ranked **3** have a probability of becoming no longer viable: **3** %
- Percentage of businesses ranked **3: 15** %
- Across all US businesses, the average probability of becoming no longer viable:**14** %

Portfolio Comparison

Compared to All US Businesses within the same MODEL SEGMENT:

- Model Segment :**Established Trade Payments**
- Level of Risk:**Low Risk**
- Businesses ranked **4** within this model segment have a probability of becoming no longer viable: **4** %
- Percentage of businesses ranked **4** with this model segment: **11** %
- Within this model segment, the average probability of becoming no longer viable:**5** %

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Data Depth Indicator

Data Depth Indicator:

Rich Firmographics
Extensive Commercial Trading Activity
Basic Financial Attributes

Greater data depth can increase the precision of the D&B Viability Rating assessment.

To help improve the current data depth of this company, you can ask D&B to make a personalized request to this company on your behalf to obtain its latest financial information. To make the request, click the link below. Note, the company must be saved to a folder before the request can be made.

Request Financial Statements

Reference the FINANCIALS tab for this company to monitor the status of your request.

Company Profile:

Company Profile Details:

- Financial Data: **False**
- Trade Payments:
- Company Size:
- Years in Business:

Z

Subsidiary

FAILURE SCORE FORMERLY FINANCIAL STRESS SCORE

64

High Risk (1) Low Risk (100)

- Low proportion of satisfactory payment experiences to total payment experiences
- UCC Filings reported
- Evidence of open suits and liens

Level of Risk	Raw Score	Probability of Failure	Average Probability of Failure for Businesses in D&B Database	Class
Moderate	1502	0.16 %	0.48	3

Business and Industry Trends

BUSINESS AND INDUSTRY COMPARISON

Selected Segments of Business Attributes

Norms	National %
This Business	64
Region:(NORTHEAST)	33
Industry:FINANCIAL SERVICES	42
Employee range:	-
Years in Business:(11-25)	43

DELINQUENCY SCORE FORMERLY COMMERCIAL CREDIT SCORE

89

High Risk (1) Low Risk (100)

- Higher risk industry based on delinquency rates for this industry
- Evidence of open suits and liens

Level of Risk	Raw Score	Probability of Delinquency	Compared to Businesses in D&B Database	Class
Low-Moderate	575	1.68 %	10.2 %	2

Business and Industry Trends

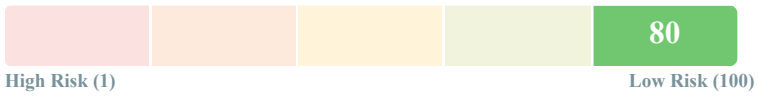
BUSINESS AND INDUSTRY COMPARISON

Selected Segments of Business Attributes

Norms	National %
This Business	89
Region:(NORTHEAST)	43
Industry:FINANCIAL SERVICES	32
Employee range:	-
Years in Business:(11-25)	46

26

D&B PAYDEX



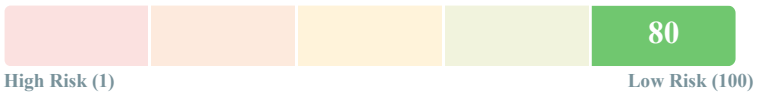
When weighted by amount, Payments to suppliers average 0 Pays on time

- High risk of late payment (Average 30 to 120 days beyond terms)
- Medium risk of late payment (Average 30 days or less beyond terms)
- Low risk of late payment (Average prompt to 30+ days sooner)

Industry Median: 80

Equals Pays On Time

D&B 3 MONTH PAYDEX



Based on payments collected 3 months ago.

When weighted by amount, Payments to suppliers average ON TERMS

- High risk of late payment (Average 30 to 120 days beyond terms)
- Medium risk of late payment (Average 30 days or less beyond terms)
- Low risk of late payment (Average prompt to 30+ days sooner)

Industry Median: 80

Equals Pays On Time

Business and Industry Trends

6324 - Hospital/medical service plan

D&B RATING

Current Rating as of 07/02/2011

Employee Size

ERN : employees-na

Trade Payments

Currency: All figures shown in USD unless otherwise stated

TRADE PAYMENTS SUMMARY (Based on 24 months of data)

Overall Payment Behaviour
0
Days Beyond Terms

Highest Now Owing :
1,000 (USD)

% of Trade Within Terms
100%

Total Trade Experiences:
16

Largest High Credit :
40,000 (USD)

Average High Credit :
20,500 (USD)

Highest Past Due
0 (USD)

Total Unfavorable Comments :
0

Largest High Credit:
0 (USD)

Total Placed in Collections:
0

Largest High Credit:
0 (USD)

D&B PAYDEX

When weighted by amount, Payments to suppliers average 0 Pays on time

- High risk of late payment (Average 30 to 120 days beyond terms)
- Medium risk of late payment (Average 30 days or less beyond terms)
- Low risk of late payment (Average prompt to 30+ days sooner)

Industry Median: 80

Equals Pays On Time

D&B 3 MONTH PAYDEX

Based on payments collected 3 months ago.

When weighted by amount, Payments to suppliers average ON TERMS

- High risk of late payment (Average 30 to 120 days beyond terms)
- Medium risk of late payment (Average 30 days or less beyond terms)
- Low risk of late payment (Average prompt to 30+ days sooner)

Industry Median: 80

Equals Pays On Time

BUSINESS AND INDUSTRY TRENDS

Based on 24 months of data

6324 - Hospital/medical service plan

	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23	10/23	11/23	12/23	1/24	2/24	3/24	4/24	5/24	Current 2024
This Business	80	80	80	80	80	80	80	80	79	79	80	80	80	79	79	79	79	80	80	80	80	80	80	80
Industry Quartile																								
Upper	-	-	80	-	-	80	-	-	80	-	-	80	-	-	80	-	-	80	-	-	80	-	-	-
Median	-	-	80	-	-	80	-	-	80	-	-	80	-	-	80	-	-	80	-	-	80	-	-	-

	7/22	8/22	9/22	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23	10/23	11/23	12/23	1/24	2/24	3/24	4/24	5/24	Current 2024
Lower	-	-	73	-	-	73	-	-	73	-	-	74	-	-	74	-	-	75	-	-	74	-	-	-

TRADE PAYMENTS BY CREDIT EXTENDED (Based on 12 months of data)

Range of Credit Extended (US$)	Number of Payment Experiences	Total Value	% Within Terms
100,000 & over	0	0 (USD)	0
50,000 - 99,999	0	0 (USD)	0
15,000 - 49,999	1	40,000 (USD)	100
5,000 - 14,999	0	0 (USD)	0
1,000 - 4,999	1	1,000 (USD)	100
Less than 1,000	0	0 (USD)	0

TRADE PAYMENTS BY INDUSTRY (BASED ON 24 MONTHS OF DATA)

Collapse All | Expand All

Industry Category	Number of Payment Experiences	Largest High Credit (US$)	% Within Terms (Expand to View)	1 - 30 Days Late (%)	31 - 60 Days Late (%)	61 - 90 Days Late (%)	91 + Days Late (%)
93 - Public Finance Taxation and Monetary Policy	1	40,000	100	0	0	0	0
9311 - Public finance	1	40,000	100	0	0	0	0
99 - Nonclassifiable Establishments	1	1,000	100	0	0	0	0
9999 - Nonclassified	1	1,000	100	0	0	0	0

TRADE LINES

Date of Experience	Payment Status	Selling Terms	High Credit (US$)	Now Owes (US$)	Past Due (US$)	Months Since Last Sale
05/24	Pays Promptly	-	1,000	1,000	0	-
05/24	-	Cash account	100	0	0	1
05/24	-	Cash account	50	0	0	1
04/24	-	Cash account	100	0	0	1
04/24	-	Cash account	50	0	0	Between 2 and 3 Months
04/24	-	Cash account	50	0	0	1
03/24	-	Cash account	50	0	0	1
02/24	-	Cash account	1,000	0	0	1
02/24	-	Cash account	100	0	0	1
02/24	-	Cash account	50	0	0	1
02/24	-	Cash account	50	0	0	1
01/24	-	Cash account	50	0	0	1
08/23	Pays Promptly	-	40,000	0	0	1
07/23	-	Cash account	50	0	0	1
07/23	-	Cash account	50	0	0	Between 2 and 3 Months
06/22	-	Cash account	50	0	0	Between 6 and 12 Months

OTHER PAYMENT CATEGORIES

Other Payment Categories	Experience	Total Amount
Cash experiences	14	1,800 (USD)
Payment record unknown	0	0 (USD)

26

Other Payment Categories	Experience	Total Amount
Unfavorable comments	0	0 (USD)
Placed for collections	0	0 (USD)
Total in D&B's file	16	42,800 (USD)

Accounts are sometimes placed for collection even though the existence or amount of the debt is disputed. Payment experiences reflect how bills are met in relation to the terms granted. In some instances payment beyond terms can be the result of disputes over merchandise, skipped invoices etc. Each experience shown represents a separate account reported by a supplier. Updated trade experiences replace those previously reported.

Legal Events

Currency: All figures shown in USD unless otherwise stated

The following Public Filing data is for information purposes only and is not the official record. Certified copies can only be obtained from the official source.

Bankruptcies	Judgements	Liens	Suits	UCCs
No	0	1	239	664
	Latest Filing: -	Latest Filing: 11/15/2023	Latest Filing: 02/08/2024	Latest Filing: 02/20/2024

EVENTS

Lien - Tax Lien

Filing Date	11/15/2023
Filing Number	23-0786424
status	Open
Date Status Attained	11/15/2023
Received Date	01/15/2024
Amount	237 (USD)
Debtors	CIGNA HEALTH AND LIFE INSURANCE
Creditors	TAX COLLECTOR
Court	LOS ANGELES COUNTY RECORDER OF DEEDS, NORWALK, CA

Suit

Filing Date	02/08/2024
Filing Number	2024-031469-CC-23
status	Pending
Date Status Attained	02/08/2024
Received Date	02/13/2024
Plaintiffs	JORGE DE LA PEDRAJA, M.D., P.A.
Defendant	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Court	DADE COUNTY DISTRICT COURT - NORTH DADE, MIAMI, FL

Suit

26

Filing Date	02/05/2024
Filing Number	2024-026939-SP-23
status	Pending
Date Status Attained	02/05/2024
Received Date	02/07/2024
Plaintiffs	JORGE DE LA PEDRAJA, M.D., P.A.
Defendant	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Court	DADE COUNTY DISTRICT COURT - NORTH DADE, MIAMI, FL

Suit

Filing Date	08/25/2023
Filing Number	2023CV000874
status	Pending
Date Status Attained	08/25/2023
Received Date	10/26/2023
Plaintiffs	LATZ, HEATHER D., CEDARBURG, WI
Defendant	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Defendant	AND OTHERS
Court	OUTAGAMIE COUNTY CIRCUIT COURT, APPLETON, WI

Suit

Filing Date	05/08/2023
Filing Number	2023CV003308
status	Pending
Date Status Attained	05/08/2023
Received Date	06/23/2023
Plaintiffs	KING, JYLIN, MILWAUKEE, WI
Defendant	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Defendant	AND OTHERS
Court	MILWAUKEE COUNTY CIRCUIT COURT, MILWAUKEE, WI

Suit

Filing Date	04/17/2023
Filing Number	CV23978133
status	Pending
Date Status Attained	04/17/2023
Received Date	05/11/2023
Plaintiffs	S BOYD
Defendant	CIGNA HEALTH AND LIFE INSURANCE COMPANY

26

Court	CUYAHOGA COUNTY COMMON PLEAS COURT, CLEVELAND, OH

Suit

Filing Date	04/03/2023
Filing Number	202301316079CJC
status	Dismissed
Date Status Attained	05/30/2023
Received Date	02/26/2024
Amount	3,246 (USD)
Plaintiffs	PATRICK FITZGIBBON
Defendant	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Court	ORANGE COUNTY SMALL CLAIMS COURT/SANTA ANA, SANTA ANA, CA

Suit

Filing Date	04/14/2021
Filing Number	502021CA004826XXXXMB
status	Pending
Date Status Attained	04/14/2021
Received Date	04/28/2021
Plaintiffs	NEUROSURGICAL CONSULTANTS OF SOUTH FLORIDA LLC,
Defendant	CIGNA HEALTH AND LIFE INSURANCE COMPANY,
Court	PALM BEACH COUNTY CIRCUIT COURT, WEST PALM BEACH, FL

Suit

Filing Date	07/08/2020
Filing Number	2020CV001408
status	Pending
Date Status Attained	07/08/2020
Received Date	01/21/2021
Plaintiffs	HANSEN, ALANA, VERONA, WI
Defendant	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Defendant	AND OTHERS
Court	DANE COUNTY CIRCUIT COURT, MADISON, WI

Suit

Filing Date	02/28/2020
Filing Number	2020CV000032
status	Pending
Date Status Attained	02/28/2020

26

Received Date	06/11/2020
Plaintiffs	NEJEDLO, MARCUS, KAUKAUNA, WI
Defendant	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Defendant	AND OTHERS
Court	CALUMET COUNTY CIRCUIT COURT, CHILTON, WI

Suit

Filing Date	11/01/2019
Filing Number	CV2019112224
status	Pending
Date Status Attained	11/01/2019
Received Date	11/14/2019
Plaintiffs	GENTRY ANTHONY G
Defendant	CIGNA HEALTH AND LIFE INSURANCE
Defendant	AND OTHERS
Court	BUTLER COUNTY COMMON PLEAS COURT, HAMILTON, OH

UCC Filing - Original

Filing Date	03/28/2022
Filing Number	0005055615
Received Date	04/29/2022
Collateral	Leased Assets including proceeds and products - Leased Equipment including proceeds and products
Secured Party	LENOVO FINANCIAL SERVICES, JACKSONVILLE, FL
Debtors	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Filing Office	UCC COMMERCIAL RECORDING DIVISION, HARTFORD, CT

UCC Filing - Original

Filing Date	03/28/2022
Filing Number	0005055614
Received Date	04/29/2022
Collateral	Leased Assets including proceeds and products - Leased Equipment including proceeds and products
Secured Party	LENOVO FINANCIAL SERVICES, JACKSONVILLE, FL
Debtors	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Filing Office	UCC COMMERCIAL RECORDING DIVISION, HARTFORD, CT

UCC Filing - Original

Filing Date	01/28/2022
Filing Number	0005043620

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Received Date	03/04/2022
Collateral	Assets including proceeds and products - Equipment including proceeds and products
Secured Party	LENOVO FINANCIAL SERVICES, JACKSONVILLE, FL
Debtors	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Filing Office	UCC COMMERCIAL RECORDING DIVISION, HARTFORD, CT

UCC Filing - Original

Filing Date	12/29/2021
Filing Number	0005037471
Received Date	01/14/2022
Collateral	Assets including proceeds and products - Equipment including proceeds and products
Secured Party	LENOVO FINANCIAL SERVICES, JACKSONVILLE, FL
Debtors	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Filing Office	UCC COMMERCIAL RECORDING DIVISION, HARTFORD, CT

UCC Filing - Original

Filing Date	12/31/2020
Filing Number	0003419414
Received Date	04/09/2021
Collateral	Negotiable instruments and proceeds - Account(s) and proceeds
Secured Party	LIFE INSURANCE COMPANY OF NORTH AMERICA, PHILADELPHIA, PA
Debtors	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Filing Office	UCC COMMERCIAL RECORDING DIVISION, HARTFORD, CT

UCC Filing - Original

Filing Date	11/20/2018
Filing Number	0003276294
Received Date	01/11/2019
Collateral	Assets including proceeds and products - Equipment including proceeds and products
Secured Party	LENOVO FINANCIAL SERVICES, JACKONVILLE, FL
Debtors	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Filing Office	UCC COMMERCIAL RECORDING DIVISION, HARTFORD, CT

UCC Filing - Original

Filing Date	03/22/2018
Filing Number	0003232447
Received Date	04/10/2018
Collateral	Assets including proceeds and products - Equipment including proceeds and products
Secured Party	LENOVO FINANCIAL SERVICES, JACKSONVILLE, FL

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Debtors	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Filing Office	UCC COMMERCIAL RECORDING DIVISION, HARTFORD, CT

UCC Filing - Original

Filing Date	11/15/2016
Filing Number	0003150444
Received Date	01/20/2017
Collateral	Assets including proceeds and products - Computer equipment including proceeds and products
Secured Party	LENOVO FINANCIAL SERVICES, JACKSONVILLE, FL
Debtors	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Filing Office	UCC COMMERCIAL RECORDING DIVISION, HARTFORD, CT

UCC Filing - Original

Filing Date	07/22/2016
Filing Number	0003132859
Received Date	09/09/2016
Collateral	Assets including proceeds and products - Computer equipment including proceeds and products
Secured Party	LENOVO FINANCIAL SERVICES, JACKSONVILLE, FL
Debtors	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Filing Office	UCC COMMERCIAL RECORDING DIVISION, HARTFORD, CT

UCC Filing - Original

Filing Date	08/13/2013
Filing Number	0002952403
Received Date	09/26/2013
Collateral	Account(s) and proceeds - General intangibles(s) and proceeds - Chattel paper and proceeds - Leased Computer equipment and proceeds - Leased Equipment and proceeds
Secured Party	PNC EQUIPMENT FINANCE, LLC, LISLE, IL
Debtors	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Filing Office	UCC COMMERCIAL RECORDING DIVISION, HARTFORD, CT

The public record items contained in this report may have been paid, terminated, vacated or released prior to the date this report was printed. This information may not be reproduced in whole or in part by any means of reproduction.

There may be additional UCC Filings in D&Bs file on this company available by contacting 1-800-234-3867.

There may be additional suits, liens, or judgments in D&B's file on this company available in the U.S. Public Records Database, also covered under your contract. If you would like more information on this database, please contact the Customer Resource Center at 1-800-234-3867.

If it is indicated that there are defendants other than the report subject, the lawsuit may be an action to clear title to property and does not necessarily imply a claim for money against the subject.

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A lien holder can file the same lien in more than one filing location. The appearance of multiple liens filed by the same lien holder against a debtor may be indicative of such an occurrence.

Special Events

Currency: All figures shown in USD unless otherwise stated

There are no Special Events recorded for this business.

Financials - D&B

Currency: All figures shown in USD unless otherwise stated

A detailed financial statement is not available from this company for publication.

Currency: All figures shown in USD unless otherwise stated

A detailed financial statement is not available from this company for publication.

Currency: All figures shown in USD unless otherwise stated

D&B currently has no financial information on file for this company

D&B currently has no financial information on file for this company.

Currency: All figures shown in USD unless otherwise stated

Currency: All figures shown in USD unless otherwise stated

D&B currently has no financial information on file for this company

Currency: All figures shown in USD unless otherwise stated

D&B currently has no financial information on file for this company

Company Profile

Currency: All figures shown in USD unless otherwise stated

COMPANY OVERVIEW

D-U-N-S
83-174-4102

Mailing Address
UNITED STATES

Age (Year Started)
28 Years (1996)

Legal Form
Unknown

Telephone
+1 800 997 1654

Named Principal
David Cordani , CEO-PRES

History Record
Clear

Present Control Succeeded
2008

Line of Business
Hospital/medical service plan

Date Incorporated
03/05/2010

SIC
6324

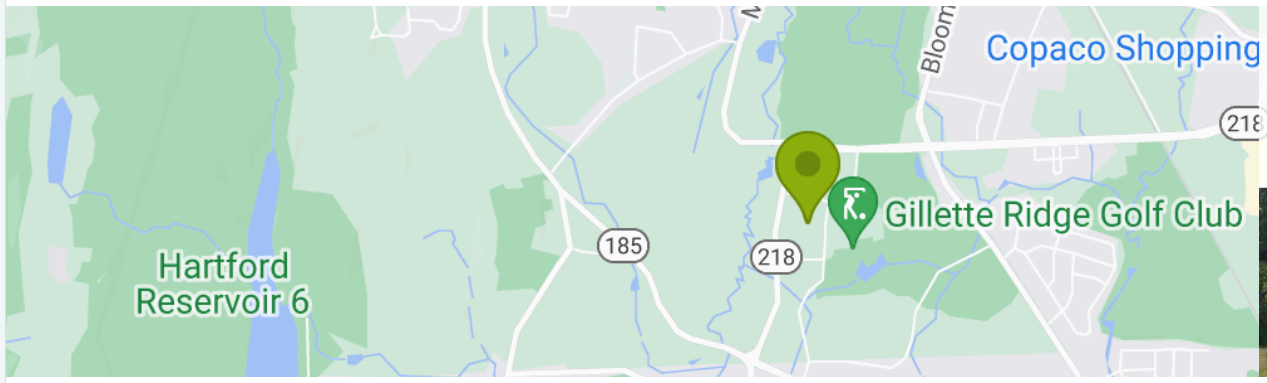
Business Commenced On
1996

NAICS
524114

State of Incorporation
CONNECTICUT

Ownership

Not publicly traded



Street Address:
900 Cottage Grove Rd,
Bloomfield, CT, 06002,
United States Of America

BUSINESS REGISTRATION

Corporate and business registrations reported by the secretary of state or other official source as of: 2024-06-04
This data is for informational purposes only, certification can only be obtained through the Office of the Secretary of State.

Registered Name	CIGNA HEALTH AND LIFE INSURANCE COMPANY
Corporation Type	Unknown
State of Incorporation	CONNECTICUT
Registration ID	0991480
Registration Status	ACTIVE
Filing Date	03/05/2010
Where Filed	SECRETARY OF STATE/CORPORATIONS DIVISION

PRINCIPALS

Officers

DAVID CORDANI, CEO-PRES
LISA BACUS, EXEC V PRES

Directors

DIRECTOR(S): THE OFFICER(S)

COMPANY EVENTS

The following information was reported on: 05/13/2024

The Connecticut Secretary of state's business registrations file showed that Cigna Health And Life Insurance Company was registered as a Corporation on March 5, 2010, under file registration number 0991480.

Business started 1996. Present control succeeded April 2008. 100% of capital stock is owned by parent company.

CONTROL CHANGE:.

On July 1, 2011, sources stated that Connecticut General Life Insurance Company, Bloomfield, CT, has acquired Alta Health & Life Insurance Company, Carmel, IN, on April 1, 2008. With this transaction, Alta Health & Life Insurance Company became a subsidiary of Connecticut General Life Insurance Company. In the Fall of 2010, Alta Health & Life Insurance Company changed its name to Cigna Health And Life Insurance Company and redomiciled form Indiana to Connecticut. Further details could not be confirmed.

DAVID CORDANI. Antecedents not available.

LISA BACUS. Antecedents not available.

Business address has changed from 11595 North Meridian Street Suite 600, Carmel, IN, 46032 to 900 Cottage Grove Rd, Bloomfield, CT, 06002.

BUSINESS ACTIVITIES AND EMPLOYEES

The following information was reported on: 05/13/2024

Business Information

Trade Names	(SUBSIDIARY OF CONNECTICUT GENERAL LIFE INSURANCE COMPANY, BLOOMFIELD, CT); CHLIC

Business Information

Description	Subsidiary of Connecticut General Life Insurance Company, Bloomfield, CT started 1865 which operates as a life insurance carrier, specializing in life insurance. As noted, this company is a subsidiary of Connecticut General Life Insurance Company, Duns number 006917082, and reference is made to that report for background information on the parent company and its management. Operates as a hospital or medical insurance plan carrier, specializing in health maintenance organization (HMO) coverage. Terms are undetermined. Sells to Unknown. Territory : Unknown.
Employees	Undetermined which includes officer(s). Undetermined employed here.
Financing Status	Unsecured
Facilities	Occupies premises in a building.

Related Concerns

SIC/NAICS Information

Industry Code	Description	Percentage of Business
6324	Hospital/medical service plan	-
63249903	Health Maintenance Organization (HMO), insurance only	-

NAICS Codes	NAICS Description
524114	Direct Health and Medical Insurance Carriers

GOVERNMENT ACTIVITY

Activity Summary

Borrower(Dir/Guar)	No
Administrative Debt	No
Contractor	No
Grantee	No
Party excluded from federal program(s)	No

Your Information

Record additional information about this company to supplement the D&B information.

> Note: Information entered in this section will not be added to D&B's central repository and will be kept private under your user ID. Only you will be able to view the information.

In Folders: View

Account Number

Endorsement/Billing Reference *

kate.gruevska@cigna.com

Sales Representatives

Credit Limit

Total Outstanding

Your Information Currency

US Dollar (USD)

CIGNA HEALTH AND LIFE INSURANCE COMPANY
CIGNA HEALTH AND LIFE INSURANCE COMPANY

attn Tax Dept - C6tax
900 COTTAGE GROVE RD
HARTFORD, CT 06152-0001

DETACH HERE AND DISPLAY RECEIPT IN A CONSPICUOUS PLACE

CITY OF CORAL GABLES, FLORIDA

LOCAL BUSINESS TAX RECEIPT

THIS IS NOT A BILL-DO NOT PAY

CUST. NO. 191741
RECEIPT NO.
BT-0025000022

2023-2024

BUSINESS NAME: CIGNA HEALTH AND LIFE INSURANCE COMPANY
DBA NAME: CIGNA HEALTH AND LIFE INSURANCE COMPANY
LOCATION: VARIOUS LOCATIONS

CLASSIFICATION:	NO. OF UNITS	UNIT DESCRIPTION	AMOUNT PAID: $ 435.30
1 Insurance Carriers			
2			
3			
4			
5			
6			

BUSINESS TAX RECPT RENEWAL

VALID ONLY AT LOCATION ABOVE.
RECEIPT EXPIRES 09/30/2024

** This receipt does not constitute authority to begin operating at this location without a Certificate of Use and Inspection Approval **

Detail by Entity Name

Foreign Profit Corporation
CIGNA HEALTH AND LIFE INSURANCE COMPANY

Filing Information

Document Number	F96000002814
FEI/EIN Number	59-1031071
Date Filed	06/04/1996
State	CT
Status	ACTIVE
Last Event	AMENDMENT AND NAME CHANGE
Event Date Filed	03/24/2010
Event Effective Date	NONE

Principal Address

900 Cottage Grove Road
Bloomfield, CT 06002

Changed: 06/25/2020

Mailing Address

900 Cottage Grove Road
Bloomfield, CT 06002

Changed: 06/25/2020

Registered Agent Name & Address

CHIEF FINANCIAL OFFICER
200 E. GAINES ST
TALLAHASSEE, FL 32399-0000

Name Changed: 03/17/2003

Address Changed: 04/07/2014

Officer/Director Detail

Name & Address

Title Director

BUCKLEY, TIMOTHY
900 Cottage Grove Road
Bloomfield, CT 06002

Title Director

LABONTE, TRACY
900 Cottage Grove Road
Bloomfield, CT 06002

Title Director, CFO

ROTTKAMP, JOHN
900 Cottage Grove Road
Bloomfield, CT 06002

Title Director

RUSSELL, DAVID
900 Cottage Grove Road
Bloomfield, CT 06002

Title Director

SNOW, CHRISTOPHER
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

ABATE, ANTHONY
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

AUSTIN, KAREN
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

BARNES, GREGORY
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

BARNETT, PETER
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

BERARDO, JEFF
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

BLAKESLEE, ERIC
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

BOWE, CHRISTOPHER
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

BRISSETT, STEPHEN
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

CASTELLVI, CHRISTINE
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

CETTI, WILLIAM
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

CHUCHRO, PETER
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

CROOKE, STEVEN
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

CULP, GARY
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

DILL, KELLY
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

DILLON, TERRENCE
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

ERICKSON, KIRK
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

EVELYN, BONNIE
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

FITZPATRICK, JAMES
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

FLEMING, MARK
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

FUNDERBURK, KIMBERLY
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

GRAY, RICHARD
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

HART, JOANNE
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

HINMAN, LINDY
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

HOLGERSON, BRYAN
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

HOLZLI, TIMOTHY
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

HOPKINS, LORI
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

II, MATTHEW TOTTERDALE
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

JEFFREYS, MARC
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

JOHNSON, ROBERT
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

JORDAL, KRISTIN
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

JOSEPHS, M.D., SCOTT
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

KENYON, MATTHEW
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

KHAN M.D., M.M., ASLAM
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

KOBUS, DAVID
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

KOCHER, RYAN
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

KRUPP, TARA
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

LAMBERT, SCOTT
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

LEWIS, EDWARD
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

LIPSON, GREG
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

MARTINEZ, ERIC
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

MAZLISH, LEONARD
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

MIRABELLA, MORRIS
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

NEMECEK, DOUGLAS
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

OCHAL, MARK
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

O'NEIL, KATHLEEN
900 Cottage Grove Road
Bloomfield, CT 06002

Title CHIEF MEDICAL OFFICER

JOSEPHS, M.D., SCOTT
900 Cottage Grove Road
Bloomfield, CT 06002

Title Secretary

MORROW, ALICIA
900 Cottage Grove Road
Bloomfield, CT 06002

Title Treasurer

LAMBERT, SCOTT
900 Cottage Grove Road
Bloomfield, CT 06002

Title Asst. Secretary

WILLIAMS, ROSINA
900 Cottage Grove Road
Bloomfield, CT 06002

Title Asst. Secretary

WEGRZYNIAK, HEATHER
900 Cottage Grove Road
Bloomfield, CT 06002

Title Asst. Secretary

UNNERSTALL, CHRISTOPHER
900 Cottage Grove Road
Bloomfield, CT 06002

Title Asst. Secretary

TULLOCH, KIMBERLY
900 Cottage Grove Road
Bloomfield, CT 06002

Title Asst. Treasurer

WARFORD, ELIZABETH
900 Cottage Grove Road
Bloomfield, CT 06002

Title Asst. Treasurer

HART, JOANNE
900 Cottage Grove Road
Bloomfield, CT 06002

Title Asst. Treasurer

FLEMING, MARK
900 Cottage Grove Road
Bloomfield, CT 06002

Annual Reports

Report Year	Filed Date
2023	03/11/2023
2023	04/06/2023
2024	04/30/2024

Document Images

04/30/2024 -- ANNUAL REPORT	View image in PDF format
04/10/2023 -- AMENDED ANNUAL REPORT	View image in PDF format
04/06/2023 -- AMENDED ANNUAL REPORT	View image in PDF format
03/11/2023 -- ANNUAL REPORT	View image in PDF format
04/21/2022 -- ANNUAL REPORT	View image in PDF format
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06/25/2020 -- ANNUAL REPORT	View image in PDF format
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01/21/2008 -- ANNUAL REPORT	View image in PDF format
03/13/2007 -- ANNUAL REPORT	View image in PDF format
03/09/2006 -- ANNUAL REPORT	View image in PDF format
01/18/2005 -- ANNUAL REPORT	View image in PDF format
07/07/2004 -- ANNUAL REPORT	View image in PDF format
05/05/2003 -- ANNUAL REPORT	View image in PDF format
03/27/2002 -- ANNUAL REPORT	View image in PDF format
02/13/2001 -- ANNUAL REPORT	View image in PDF format
06/07/2000 -- ANNUAL REPORT	View image in PDF format
11/23/1999 -- Name Change	View image in PDF format
05/04/1999 -- ANNUAL REPORT	View image in PDF format
02/19/1998 -- ANNUAL REPORT	View image in PDF format
09/17/1997 -- ANNUAL REPORT	View image in PDF format
06/04/1996 -- DOCUMENTS PRIOR TO 1997	View image in PDF format
06/04/1996 -- Foreign Qualification	View image in PDF format

CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY)
06/13/2024

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Aon Risk Services Central, Inc.
Philadelphia PA Office
100 North 18th Street
15th Floor
Philadelphia PA 19103 USA

CONTACT NAME:
PHONE (A/C. No. Ext): (866) 283-7122 **FAX (A/C. No.):** (800) 363-0105
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A:	ACE American Insurance Company	22667
INSURER B:	Indemnity Insurance Co of North America	43575
INSURER C:	Lexington Insurance Company	19437
INSURER D:		
INSURER E:		
INSURER F:		

INSURED
The Cigna Group
900 Cottage Grove Road
Bloomfield CT 06002 USA

COVERAGES **CERTIFICATE NUMBER:** 570106348517 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS,

Limits shown are as requested

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X **COMMERCIAL GENERAL LIABILITY** CLAIMS-MADE / X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY / PRO-JECT / LOC OTHER:	Y	Y	HDOG47313958 SIR applies per policy terms & conditions	07/01/2023	07/01/2024	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$2,000,000 $2,000,000 $5,000 $2,000,000 $4,000,000 $2,000,000
A	**AUTOMOBILE LIABILITY** X ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY	Y	Y	ISA H10708904 SIR applies per policy terms & conditions	07/01/2023	07/01/2024	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$2,000,000
	UMBRELLA LIAB / OCCUR **EXCESS LIAB** / CLAIMS-MADE DED / RETENTION						EACH OCCURRENCE AGGREGATE	
B	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER **(Mandatory in NH)** N If yes, describe under DESCRIPTION OF OPERATIONS below	N / A	Y	WLRC70313728	07/01/2023	07/01/2024	X PER STATUTE / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE-EA EMPLOYEE E.L. DISEASE-POLICY LIMIT	$1,000,000 $1,000,000 $1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

The Products Liability policy #35407110 evidenced on this certificate is a claims made policy. Certificate Holder is included as Additional Insured in accordance with the policy provisions of the General Liability and Automobile Liability policies where required by written contract. General Liability and Automobile Liability policies evidenced herein are Primary and Non-Contributory to other insurance available to an Additional Insured, but only in accordance with the policy provisions where required by written contract. A Waiver of Subrogation is granted in favor of Certificate Holder in accordance with the policy provisions of the General Liability, Automobile Liability and Workers' Compensation policies where required by written contract. See the attached list of additional Named Insureds.

CERTIFICATE HOLDER

City of Coral Gables
Attn: Insurance Compliance
PO Box 100085-CE
Duluth GA 30096 USA

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Aon Risk Services Central, Inc.

Holder Identifier :

Certificate No : 570106348517

AGENCY CUSTOMER ID: 10042023

LOC #:

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
Aon Risk Services Central, Inc.	The Cigna Group
POLICY NUMBER: See Certificate Numbe 570106348517	
CARRIER: See Certificate Numbe 570106348517 / NAIC CODE:	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: ACORD 25 **FORM TITLE:** Certificate of Liability Insurance

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER	
INSURER	
INSURER	
INSURER	

ADDITIONAL POLICIES If a policy below does not include limit information, refer to the corresponding policy on the ACORD certificate form for policy limits.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS	
	OTHER							
C	Products Liability			35407110 Express Scripts Only	07/01/2023	07/01/2024	Comp/Op Agg	$4,000,000

Additional Named Insureds (1 of 2)

Accredo Health Group, Inc.
Accredo Health, Incorporated
AHG of New York, Inc.
Airport Holdings, LLC
Allegiance Benefit Plan Management, Inc.
Allegiance Cobra Services, Inc.
Bravo Health Mid-Atlantic, Inc.
Brighter Inc.
Biopartners in Care, Inc.
Brookwood Management Partners, LLC
Care Continuum, Inc.
CareCore National Group, LLC
CareCore National Intermediate Holdings, LLC
CareCore National, LLC
CareCore NJ, LLC
CareNext Managed Care, LLC
CareNext Post-Acute, LLC
Chiro Alliance Corporation
Cigna Corporate Services, LLC
Cigna Dental Health of California, Inc.
Cigna Dental Health of Delaware, Inc.
Cigna Dental Health of Florida, Inc.
Cigna Dental Health of Kentucky, Inc.
Cigna Dental Health of Maryland, Inc.
Cigna Dental Health of Missouri
Cigna Dental Health of New Jersey, Inc.
Cigna Dental Health of North Carolina, Inc.
Cigna Dental Health of Ohio, Inc.
Cigna Dental Health of Pennsylvania, Inc.
Cigna Dental Health of Texas, Inc.
Cigna Dental Health of Virginia, Inc.
Cigna Dental Health Plan of Arizona, Inc.
Cigna Dental Health, Inc.
Cigna European Services (UK) Limited
Cigna Health and Life Insurance Company
Cigna Health Management, Inc.
Cigna Healthcare of Arizona, Inc.
Cigna Healthcare of California, Inc.
Cigna HealthCare of Colorado, Inc.
Cigna HealthCare of Connecticut, Inc.
Cigna HealthCare of Florida, Inc.
Cigna Healthcare of Georgia, Inc.
Cigna HealthCare of Illinois, Inc.
Cigna HealthCare of Indiana, Inc.
Cigna HealthCare of New Hampshire, Inc.
Cigna HealthCare of New Jersey, Inc.
Cigna Healthcare of North Carolina, Inc.
Cigna HealthCare of St. Louis, Inc.
Cigna HealthCare of South Carolina, Inc.
Cigna Healthcare of Tennessee, Inc.
Cigna HealthCare of Texas, Inc.
Cigna Healthcare of Utah, Inc.
Cigna Healthcare, Inc.
Connecticut General Life Insurance Company
Cotricity Health Group, PC
CuraScript, Inc.
Diversified NY IPA, Inc.
Diversified Pharmaceutical Services, Inc.
Econdisc Contracting Solutions, LLC
ESI Canada
ESI GP Canada ULC
ESI GP Holdings, Inc.
ESI GP2 Canada ULC
ESI Mail Order Processing, Inc.
ESI Mail Pharmacy Service, Inc.
ESI Partnership
ESI Resources, Inc.
Evernorth Behavioral Care Group of California, P.C.
Evernorth Behavioral Care Group of Florida, P.A.
Evernorth Behavioral Care Group of New Jersey, P.C.
Evernorth Behavioral Care Group of New York, P.C.
Evernorth Behavioral Health Inc.
f/k/a Cigna Behavioral Health, Inc.
Evernorth Behavioral Health of California, Inc.
f/k/a Cigna Behavioral Health of California, Inc.
Evernorth Behavioral Health of Texas, Inc.
f/k/a Cigna Behavioral Health of Texas, Inc.
Evernorth Care Group f/k/a Cigna Medical Group
Evernorth Care Solutions, Inc.
Evernorth Direct Health, LLC
eviCore healthcare MSI, LLC
Express Reinsurance Company
Express Scripts Administrators LLC
Express Scripts Canada Co.
Express Scripts Canada Holding Co.
Express Scripts Canada Holding, LLC
Express Scripts Canada Services
Express Scripts Canada Wholesale
Express Scripts Holding Company
Express Scripts Holding Company, Inc.
Express Scripts, Inc.
Express Scripts Pharmaceutical Procurement, LLC

Additional Named Insureds (2 of 2)

Express Scripts Pharmacy Atlantic, Ltd.
Express Scripts Pharmacy Central, Ltd.
Express Scripts Pharmacy Ontario, Ltd.
Express Scripts Pharmacy West, Ltd.
Express Scripts Pharmacy, Inc.
Express Scripts Sales Operations, Inc.
Express Scripts Senior Care Holdings, Inc.
Express Scripts Senior Care, Inc.
Express Scripts Specialty Distribution Services, Inc.
Express Scripts Strategic Development, Inc.
Express Scripts Services Co.
Express Scripts Utilization Management Company
Freco, Inc.
Freedom Service Company, LLC
Gulfquest, LP
Healthbridge Reimbursement & Product Support, Inc.
Healthbridge, Inc.
HealthCare of Colorado, Inc.
Healthspring Life & Health Insurance Company, Inc.
Healthspring of Florida, Inc.
Healthspring USA, LLC
Healthspring, Inc.
Home Physicians Management, LLC
Innovative Product Alignment, LLC
Inside RX, LLC
Lynnfield Compounding Center, Inc.
Lynnfield Drug, Inc.
MAH Pharmacy, LLC
Matrix GPO, LLC
Matrix Healthcare Services, Inc.
MDLIVE, Inc.
Medco Containment Insurance Company of NY
Medco Containment Life Insurance Company
Medco Health Services, Inc.
Medco Health Solutions, Inc.
MedSolutions Holdings, Inc.
MedSolutions of Texas, Inc.
MHS Holdings, CV
MSI Health Organization of Texas, Inc.
MyM Technology Services, LLC
myMatrixx Holdings, LLC
myMatrixx-B, LLC
Newquest Management Northeast, LLC
Newquest Management of Alabama, LLC
Newquest, LLC
Palladian Health of Florida, LLC
Palladian Independent Practice Association, LLC
Priority Healthcare Corporation
Priority Healthcare Distribution, Inc. dba CuraScript Specialty Distribution
QPID Health, LLC
Quallent Pharmaceuticals Health LLC
Specialty Products Acquisitions, LLC
SpectraCare Health Care Ventures, Inc.
SpectraCare, Inc.
Tel-Drug of Pennsylvania, L.L.C.
Tel-Drug, Inc.
Verity Solutions Group, Inc.

CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY)
06/13/2024

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Aon Risk Services Central, Inc.
Philadelphia PA Office
100 North 18th Street
15th Floor
Philadelphia PA 19103 USA

CONTACT NAME:
PHONE (A/C. No. Ext): (866) 283-7122
FAX (A/C. No.): (800) 363-0105
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A:	ACE American Insurance Company	22667
INSURER B:	Lexington Insurance Company	19437
INSURER C:		
INSURER D:		
INSURER E:		
INSURER F:		

INSURED
The Cigna Group
900 Cottage Grove Road
Bloomfield CT 06002 USA

COVERAGES **CERTIFICATE NUMBER:** 570106348544 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS,

Limits shown are as requested

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	
							MED EXP (Any one person)	
							PERSONAL & ADV INJURY	
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	
	OTHER:							
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	
	☐ ANY AUTO						BODILY INJURY (Per person)	
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	
	☐ DED ☐ RETENTION							
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER ☐ N / A (Mandatory in NH)						E.L. EACH ACCIDENT	
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE-EA EMPLOYEE	
							E.L. DISEASE-POLICY LIMIT	
B	Cyber Liability			33085874 Security and Privacy Liab	07/01/2023	07/01/2024	Agg-Claims Made	$15,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

See attached list of additional Named Insured.

CERTIFICATE HOLDER

City of Coral Gables
Attn: Insurance Compliance
PO Box 100085-CE
Duluth GA 30096 USA

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Aon Risk Services Central, Inc.

Holder Identifier :

Certificate No : 570106348544

Additional Named Insureds (1 of 2)

Accredo Health Group, Inc.
Accredo Health, Incorporated
AHG of New York, Inc.
Airport Holdings, LLC
AS Acquisition Corp.
Biopartners in Care, Inc.
Care Continuum, Inc.
CareCore National Group, LLC
CareCore NJ, LLC (dba eviCore healthcare NJ ODS)
CCN NMO, LLC (dba eviCore healthcare IPA)
CCN-WYN IPA, LLC (dba eviCore healthcare IPA)
Chiro Alliance Corporation
Choicelinx Corporation
Cigna Arbor Life Insurance Company
CIGNA Corporation
Cigna Corporation Et Al
Cigna Dental Health of California, Inc.
Cigna Dental Health of Colorado, Inc.
Cigna Dental Health of Delaware, Inc.
Cigna Dental Health of Florida, Inc.
Cigna Dental Health of Kentucky, Inc.
Cigna Dental Health of Maryland, Inc.
Cigna Dental Health of New Jersey, Inc.
Cigna Dental Health of North Carolina, Inc.
Cigna Dental Health of Ohio, Inc.
Cigna Dental Health of Pennsylvania, Inc.
Cigna Dental Health of Texas, Inc.
Cigna Dental Health of Virginia, Inc.
Cigna Dental Health Plan of Arizona, Inc.
CIGNA EUROPE INSURANCE COMPANY S.A.-N.V.
Cigna European Services UK Limited (CESL)
Cigna European Services UK Limited, Barcelona
Cigna Global Health Benefits (CGHB)
Cigna Health and Life Insurance Company (CHLIC)
Cigna Health Management Inc.
Cigna Healthcare Eastern Technology Services Company Limited
CIGNA HEALTHCARE OF CALIFORNIA, INC.
Cigna HealthCare of Connecticut, Inc
Cigna Healthcare of Georgia, Inc.
Cigna Healthcare of South Carolina, Inc.
Cigna HealthCare of St. Louis, Inc.
Cigna HLA Technology Services LTD
Cigna Insurance Middle East S.A.L.
Cigna International Health Services BVBA
Cigna Life Insurance Company of Canada
Cigna Life Insurance Company of Europe, Madrid
Connecticut General Life Insurance Company (CGLIC)
Cotricity Health Group, PC
CuraScript, Inc.
Diversified NY IPA, Inc
Diversified Pharmaceutical Services, Inc.
DNA Direct, Inc.
Econdisc Contracting Solutions, LLC
ESI Canada
ESI GP Canada ULC
ESI GP Holdings, Inc.
ESI GP2 Canada ULC
ESI Mail Order Processing, Inc.
ESI Mail Pharmacy Service, Inc.
ESI Partnership
ESI Resources, Inc.
Evernorth Behavioral Care Group of California, P.C.
Evernorth Behavioral Care Group of Florida, P.A.
Evernorth Behavioral Care Group of New Jersey, P.C.
Evernorth Behavioral Care Group of New York, P.C.
Evernorth Behavioral Health Inc.
f/k/a Cigna Behavioral Health, Inc.
Evernorth Behavioral Health of California, Inc.
f/k/a Cigna Behavioral Health of California, Inc.
Evernorth Behavioral Health of Texas, Inc.
f/k/a Cigna Behavioral Health of Texas, Inc.
Evernorth Care Solutions, Inc.
Evernorth Direct Health, LLC
eviCore healthcare MSI, LLC (dba eviCore healthcare)
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Express Scripts Administrators LLC
Express Scripts Canada Co.
Express Scripts Canada Holding Co.
Express Scripts Canada Holding, LLC
Express Scripts Canada Services
Express Scripts Canada Wholesale
Express Scripts Holding Company, Inc.
Express Scripts Pharmaceutical Procurement, LLC
Express Scripts Pharmacy Atlantic, Ltd.
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Express Scripts Pharmacy, Inc.
Express Scripts Sales Operations, Inc.
Express Scripts Senior Care Holdings, Inc.
Express Scripts Senior Care, Inc.
Express Scripts Services Co.
Express Scripts Specialty Distribution Services, Inc.
Express Scripts Strategic Development, Inc.
Express Scripts Utilization Management Company

Additional Named Insureds (2 of 2)

Express Scripts, Inc.
Freco, Inc.
Freedom Service Company, LLC
GulfQuest, LP
Healthbridge Reimbursement & Product Support, Inc.
Healthbridge, Inc.
HealthFortis, Inc.
HealthSpring, Inc.
HealthSpring Life & Health Insurance Company, Inc.
HealthSpring of Florida, Inc.
Innovative Product Alignment, LLC
Inside RX, LLC
Integricare Healthplan of Texas, Inc.
L&C Investments, LLC
Landmark Healthcare Arizona, Inc.
Landmark Healthcare Colorado, Inc.
(dba eviCore healthcare MSK Colorado)
Landmark Healthcare New Jersey, Inc.
Landmark Healthcare New Mexico, Inc.
Landmark Healthcare Services, Inc.
(dba eviCore Healthcare MSK Services)
Landmark Healthcare, Inc.
(dba eviCore healthcare MSK)
Lynnfield Compounding Center, Inc.
Lynnfield Drug, Inc.
MAH Pharmacy, LLC
Matrix GPO, LLC
Matrix Healthcare Services, Inc.
MDLIVE, Inc.
Medco Containment Insurance Company of NY
Medco Containment Life Insurance Company
Medco Europe, LLC
Medco Europe II, LLC
Medco Health Puerto Rico, LLC
Medco Health Services, Inc.
Medco Health Solutions [Ireland] Limited
Medco Health Solutions, Inc.
Medco International Holdings, BV
MedSolutions Holdings, Inc.
MedSolutions Holdsings, Inc.
MedSolutions of Texas, Inc.
MedSolutions, Inc. (dba eviCore healthcare)
MHS Holdings, CV
MSI Health Organization of Texas, Inc.
MyM Technology Services, LLC
myMatrixx Holdings, LLC
myMatrixx-B, LLC
New Quest Management of Alabama LLC
Palladian Health of Florida, LLC
Palladian Independent Practice Association, LLC
Premerus, Inc.
Priority Healthcare Corporation
Priority Healthcare Distribution, Inc. dba CuraScript
Specialty Distribution
QPID Health, Inc.
SpectraCare Health Care Ventures, Inc.
SpectraCare, Inc.
Strategic Pharmaceutical Investments, LLC
Systemed, LLC
The Vaccine Consortium, LLC
Triad Healthcare, Inc. (dba eviCore healthcare
MSK Services of Connecticut)
Verity Solutions Group, Inc.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 06/13/2024

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PRODUCER Marsh USA LLC 1717 Arch Street Philadelphia, PA 19103-2797 Attn: Healthcare.AccountsCSS@marsh.com FAX: 212-948-1307 CN121292831-PRIM-CRIME-24-25	**CONTACT NAME:** **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:**
INSURED THE CIGNA GROUP 900 COTTAGE GROVE ROAD BLOOMFIELD, CT 06002	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** National Union Fire Insurance Co. of Pittsburgh, PA — 19445 **INSURER B :** **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** CLE-007226777-01 **REVISION NUMBER:** 1

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☐ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☐ PRO-JECT ☐ LOC ☐ OTHER:						EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG 	$ $ $ $ $ $ $
	AUTOMOBILE LIABILITY ☐ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) 	$ $ $ $ $
	☐ **UMBRELLA LIAB** ☐ OCCUR ☐ **EXCESS LIAB** ☐ CLAIMS-MADE ☐ DED ☐ RETENTION $						EACH OCCURRENCE AGGREGATE 	$ $ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A					☐ PER STATUTE ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $ $
A	CRIME / FIDELITY			04-840-42-21	04/30/2024	04/30/2025	LIMIT DEDUCTIBLE	5,000,000 2,500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

CITY OF CORAL GABLES
ATTN: INSURANCE COMPLIANCE
PO BOX 100085 CE
DULUTH, GA 30096

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Marsh USA LLC

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
Marsh USA LLC	THE CIGNA GROUP 900 COTTAGE GROVE ROAD BLOOMFIELD, CT 06002
POLICY NUMBER	
CARRIER / NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

"IF EVIDENCE OF COVERAGE IS NO LONGER REQUIRED, KINDLY RETURN THE CERTIFICATE MARKED "NO LONGER REQUIRED", AND WE WILL ADJUST OUR FILES ACCORDINGLY."

Florida Office of Insurance Regulation

CIGNA HEALTH AND LIFE INSURANCE COMPANY

Is hereby authorized to transact insurance in the State of Florida.

This certificate signifies that the company has satisfied all requirements of Florida Insurance Code for the issuance of a Life And Health Insurer Certificate Of Authority and remains subject to the laws of Florida.

Date of Issuance: February 17, 1964

No. 10 - 591031071

Kevin M. McCarty
Commissioner
Office of Insurance Regulation

Company Directory: Search Results

This information is current as of 6/19/2024

CIGNA HEALTH AND LIFE INSURANCE COMPANY

FEIN	59-1031071
Florida Company Code	05404
NAIC Company Code	67369
Company Type	LIFE AND HEALTH INSURER
Home State	CT
Web Site	http://WWW.CIGNA.COM
Authorization Type	CERTIFICATE OF AUTHORITY
Authorization Status	ACTIVE
First Licensed in Florida Date	02/17/1964

Addresses

Type	Address	Phone
ADMINISTRATIVE	900 COTTAGE GROVE ROAD, BLOOMFIELD CT 06002 United States	(860) 226-6000
HOME	900 COTTAGE GROVE ROAD, BLOOMFIELD CT 06002 United States	
MAILING	1601 CHESTNUT STREET TL14A, PHILADELPHIA PA 19192 United States	(215) 761-6810
CLAIMS WEBSITE	http://www.cigna.com	0No Phone
LOCATION OF RECORDS	900 COTTAGE GROVE ROAD, BLOOMFIELD CT 06002 United States	(860) 226-6000

Authorized Lines of Business

Line of Business	Type

VARIABLE ANNUITIES	DIRECT AND REINSURANCE
CREDIT DISABILITY	DIRECT AND REINSURANCE
VARIABLE LIFE	DIRECT AND REINSURANCE
CREDIT LIFE	DIRECT AND REINSURANCE
DISCOUNT MEDICAL PLAN	DIRECT AND REINSURANCE
GROUP LIFE AND ANNUITIES	DIRECT AND REINSURANCE
ACCIDENT AND HEALTH	DIRECT AND REINSURANCE
LIFE	DIRECT AND REINSURANCE

New Search

DISCLAIMER

The Florida Office of Insurance Regulation (“Office”) provides access to company and other information on this Web site as a public service. Although reasonable efforts have been made to ensure that all electronic information made available is current, complete and accurate, the Office does not warrant or represent that this information is current, complete and accurate. All information is subject to change on a regular basis, without notice.

The Office assumes no responsibility for any errors in the information provided, nor assumes any liability for any damages incurred as a consequence, directly or indirectly, of the use and application of any of the contents of the Office Web site. Unless otherwise noted on an individual document, file, webpage or other Web site item, the Office grants users permission to reproduce and distribute all information available on this website for non-commercial purposes and usage, as long as the contents remain unaltered and as long as it is noted that the contents have been made available by the Florida Office of Insurance Regulation.

Any electronic information or inquiries that the Office receives from a Web site user shall not be considered as, or treated as, confidential.

The inclusion of, or linking to, other web site URLs does not imply our endorsement of, nor responsibility for, those web sites, but has been done as a convenience to our Web site visitors.

EXAMPLES

The Office of Insurance Regulation company search does not require you to know exactly how Office of Insurance Regulation has the company's name recorded. It will take your input and return every name that contains your input as it appears in any part of all records. In other words, if your search is:

Floricorp

then the search will return all the names that have "Floricorp" in any part of the record. For example:

FLORICORP, INC.
FLORICORP PROPERTY AND CASUALTY COMPANY
SOUTHERN FLORICORP UNLIMITED

If you entered

Floricorp P

you would get only

FLORICORP PROPERTY AND CASUALTY COMPANY

Note that even though the whole name is searched, the service still looks for an exact match. So if you entered

FLORICORP,

(i.e., with a comma) you would only get

FLORICORP, INC.

Office of Insurance Regulation

200 East Gaines Street
Tallahassee, Fl 32399
(850) 413-3140

Office of Insurance Commissioner

CITY OF CORAL GABLES
FINANCE DEPARTMENT/PROCUREMENT DIVISION

LOBBYIST AFFIDAVIT

Solicitation Name/Number: **RFP No. 2024-020 Group Medical Insurance Services**

The following provisions shall apply to certain individuals who, in procurement matters participate in oral presentations or recorded responsiveness, responsibility or negotiation meetings and sessions:

a. The principal shall list below all technical experts or employees of the principal whose normal scope of employment does not include lobbying activities and whose sole participation in the city procurement matter involves an appearance and participation in an oral presentation before an evaluation, selection, technical review or similar committee, or recorded responsiveness, responsibility or negotiation meetings or sessions.

b. No person shall appear before any procurement committee or at any procurement responsiveness, responsibility or negotiation meeting or session on behalf of a principal unless he/she has been listed as part of the principal's team pursuant to this affidavit or has registered as a lobbyist. For purposes affidavit only, the listed members of the oral presentation or negotiation team shall not be required to separately register as lobbyists or pay any registration fees.

This affidavit will be provided by the city procurement staff to the city clerk after the proposal is submitted or prior to the oral presentation. Any changes after the original affidavit is submitted by the proposer and prior to the oral presentations, an updated copy shall be presented to the Procurement Division and the City Clerk at least twenty-four (24) hours prior scheduled time for the oral presentation session. Notwithstanding the foregoing, any person who engages in lobbying activities in addition to appearing before a procurement committee to make an oral presentation, or at a recorded procurement negotiation meeting or session, shall comply with all lobbyist registration requirements.

List of employees & technical experts:

NAME	TITLE	ROLE	COMPANY/FIRM
Beth Smith	**Vice President of Government, Education, & Hospital Verticals**	**Account Management (IC) Senior Manager**	**Cigna Health and Life Insurance Company (CHLIC)**
Osvaldo Guerra	**Manager of Government & Education**	**Sales Administration Advisor**	**Cigna Health and Life Insurance Company (CHLIC)**
Dina D' Angelo	**Existing Business Sales Representative**	**Account manager (IC) Advisor**	**Cigna Health and Life Insurance Company (CHLIC)**
Joyce Lau	**Client Account Manager**	**Client Account Support Senior Advisor**	**Cigna Health and Life Insurance Company (CHLIC)**
Yesenia Sanchez	**Vice President**	**Vice President**	**Cigna Health and Life Insurance Company (CHLIC)**
Raul Loys	**Existing Account Management Manager**	**Existing Account Management Manager**	**Cigna Health and Life Insurance Company (CHLIC)**
Dr. Marco Vitiello	**Senior Medical Executive**	**Senior Medical Executive**	**Cigna Health and Life Insurance Company (CHLIC)**

CITY OF CORAL GABLES
FINANCE DEPARTMENT/PROCUREMENT DIVISION

LOBBYIST AFFIDAVIT

I do solemnly swear that all of the foregoing information is true and correct and I will fully comply with requirements of this affidavit and the associated City of Coral Gables Lobbyist Registration requirement pursuant to Ordinance 2021-24 Section.

Authorized Signature: Kimberly L. Funderburk

Printed Name: **Kimberly L. Funderburk**

Title: **Vice President of CHLIC and Authorized Signatory** Date: 7/10/24

Bidder/Proposer's Name: **Cigna Health and Life Insurance Company (CHLIC) and Evernorth Care Solutions, Inc.**

NOTARY PUBLIC

STATE OF Georgia

COUNTY OF Fulton

On this 10th day of July, 2024, before me the undersigned Notary Public of the State of GA, personally appeared Kimberly L. Funderburk (Name(s) of individual(s) who appeared before Notary

And whose name(s) is/are subscribes to within the instrument(s), and acknowledges it's execution.

Debby F. Vetter

NOTARY PUBLIC, STATE OF GA

Debby F. Vetter (Name of notary Public; Print, Stamp or Type as Commissioned.

DEBBY F VETTER NOTARY PUBLIC COBB COUNTY, GEORGIA

SEAL OF OFFICE:

Personally know to me, or Produced

Identification:

Known to me.

(Type of Identification Produced)

CITY OF CORAL GABLES
FINANCE DEPARTMENT/PROCUREMENT DIVISION
LOBBYIST REGISTRATION FORM

SOLICITATION NAME/NUMBER: **RFP No. 2024-020 Group Medical Insurance Services**

We do not have any lobbyists associated with this solicitation.

The Bidder/Proposer certifies that it understands if it has retained a lobbyist(s) to lobby in connection with this specific competitive solicitation that each lobbyist retained has timely filed the registration or amended registration required under the City of Coral Gables Lobbyist Registration requirement pursuant to Ordinance 2021-24 as outlined below:

Lobbyist means an individual, firm, corporation, partnership, or other legal entity employed or retained, whether paid or not, by a principal, or that contracts with a third-party for economic consideration to perform lobbying activities on behalf of a principal.

Lobbying activity means any attempt to influence or encourage the passage or defeat of, or modification to, governmental actions, including, but not limited to, ordinances, resolutions, rules, regulations, executive orders, and procurement actions or decisions of the city commission, the mayor, any city board or committee, or any city personnel. The term "lobbying activity" encompasses all forms of communication, whether oral, written, or electronic, during the entire decision-making process on actions, decisions, or recommendations which foreseeably will be heard or reviewed by city personnel. This definition shall be subject to the exceptions stated below.

Procurement matter means the city's processes for the purchase of goods and services, including, but not limited to, processes related to the acquisition of: technology; public works; design services; construction, professional architecture, engineering, landscape architecture, land surveying, and mapping services; the purchase, lease or sale of real property; and the acquisition, granting, or other interest in real property.

City personnel means those city officials, officers and employees who are entrusted with the day-to-day policy setting, operation, and management of certain defined city functions or areas of responsibility, even though ultimate responsibility for such functions or areas rests with the city commission, with the exception of the City Attorney, Deputy City Attorney, and Assistant City Attorneys, advisory personnel (members of city advisory boards and agencies whose sole or primary responsibility is to recommend legislation or give advice to the city commission); and any employee of a city department or division with the authority to participate in procurement matters, when the communication involves such procurement.

Affidavit requirement. The following provisions shall apply to certain individuals who, in procurement matters participate in oral presentations or recorded negotiation meetings and sessions:

a. The principal shall list on an affidavit form, provided by the City, all technical experts or employees of the principal whose normal scope of employment does not include lobbying activities and whose sole participation in the city procurement matter involves an appearance and participation in a city procurement matter involves an appearance and participation in an oral presentation before a city certification, evaluation, selection, technical review or similar committee, or recorded negotiation meetings or sessions.

b. No person shall appear before any procurement committee or at any procurement negotiation meeting or session on behalf of a principal unless he/she has been listed as part of the principal's presentation or negotiation team or has registered as a lobbyist. For purposes of this subsection only, the listed members of the oral presentation or negotiation team shall not be required to separately register as lobbyists or pay any registration fees. The affidavit will be filed by the city procurement staff with the city clerk at the after the proposal is submitted or prior to the recorded negotiation meeting or session. Notwithstanding the foregoing, any person who engages in lobbying activities in addition to appearing before a procurement committee to make an oral presentation, or at a recorded procurement negotiation meeting or session, shall comply with all lobbyist registration requirements.

The Bidder/Proposer hereby certifies that: (select one)

__X__ It has not retained a lobbyist(s) to lobby in connection with this competitive solicitation; however, if one is retained anytime during the competitive process and prior to contract execution for this project, the lobbyist will properly register with the City Clerk's Office within two (2) business days of being retained with copy to the city procurement staff.

_____ It has retained a lobbyist(s) to lobby in connection with this competitive solicitation and certified that each lobbyist retained has timely filed the registration or amended registration required under the City of Coral Gables

CITY OF CORAL GABLES
FINANCE DEPARTMENT/PROCUREMENT DIVISION
LOBBBYIST REGISTRATION FORM

Lobbyist Registration requirement pursuant to Ordinance 2021-24 Section and that the required affidavit has been properly filed

It is a requirement of this solicitation that the following information be provided for all lobbyists retained to lobby in connection with this solicitation be listed below:

Name of Lobbyist:_____
Lobbyist's Firm (if applicable): _____
Phone: _____
E-mail: _____

Name of Lobbyist:_____
Lobbyist's Firm (if applicable): _____
Phone: _____
E-mail: _____

Name of Lobbyist:_____
Lobbyist's Firm (if applicable): _____
Phone: _____
E-mail: _____

Name of Lobbyist:_____
Lobbyist's Firm (if applicable): _____
Phone: _____
E-mail: _____

Authorized Signature: Kimberly L. Funderburk
Printed Name: Kimberly L. Funderburk
Date: 7/8/2024
Title: Vice President of CHLIC and Authorized Signatory
Bidder/Proposer Name: Cigna Health and Life Insurance Company (CHLIC) and Evernorth Care Solutions, Inc.

The Cigna Group and its predecessor companies have a long history of supporting the health care needs of Americans. We have over 200 years of history, starting with the formation of the Insurance Company of North America in 1792 and Connecticut General Life Insurance Company (CGLIC) in 1865. In 1982, The Cigna Group was formed through the combination of INA Corporation and Connecticut General Corporation (CGC), the parent companies of the Insurance Company of North America and Connecticut General Life, respectively. In 2018, we were reestablished when it completed its combination with Express Scripts.

Connecticut General Life began offering health-related coverage in 1912 and later expanded to group accident and sickness in 1919. The standard group health indemnity plan, including major medical and hospital and surgical coverage, was first introduced in 1954. CGC and INA were among the first major carriers to introduce health care cost containment and management programs as well as to explore and undertake the development of HMOs.

In 1980, INA acquired the Ross-Loos Medical Group of Los Angeles. Established in 1929, Ross-Loos was the nation's first HMO. Throughout the 1980s, we continued to develop managed care plans and services. In 1984, The Cigna Group began offering a PPO plan in Miami, Florida, and a POS plan in late 1986 at several sites.

With the acquisition of EQUICOR in 1990, we became the largest investor-owned managed care organization in the country and continues to have strong enrollment levels. In 2018, we completed the combination with Express Scripts and its subsidiaries.

The rich and exciting history of The Cigna Group reveals the foundation of experience that shapes its current plans and business strategies. We have illustrated our ability to anticipate changes and devote ourselves to our clients as we participated in our nation's dynamic growth and prosperity. Today, our companies comprise one of the nation's leading providers of member covered services, health care coverage, and insurance plan coverage to businesses and members worldwide. Our various operating subsidiaries of The Cigna Group provide plans and services. These subsidiaries include CGLIC, Cigna Health and Life Insurance Company (CHLIC), Cigna Home Delivery Pharmacy and its affiliates, Evernorth Behavioral Health, Inc., Evernorth Direct Health, LLC, Evernorth Care Solutions, Inc., Cigna Health Management, Inc., HMO or service company subsidiaries of Cigna Health Corporation, and Cigna Dental Health, Inc.

We work with many clients around the world, including Fortune 500 companies, smaller and midsize companies, organizations, institutions, and governments—many with multiple sites and members located across time zones and global borders.

More than 68,000 of our employees, in more than 30 countries and jurisdictions around the world, stand behind our geographical scope, financial strengths, and leading portfolio of plans and services. We serve over 170 million members worldwide, with 3.1 million in the US Public Sector. Their dedication to customer service and their commitment to quality truly make The Cigna Group a leading health service company. We define health as more than the absence of sickness. To us, health is intertwined with a sense of well-being and peace of mind.

Additionally, with more than 50 years of experience, Cigna Global Health Benefits is the leading provider of client-sponsored global health care benefits and services. the City can help protect employees traveling on international business by offering our Global Health Advantage plans for long-term globally mobile assignments and our Medical Benefits Abroad product, which provides coverage for unexpected injuries or illnesses that occur during short-term international business travel.

The Cigna Group has a long history of successful external validation of its quality improvement programs and remains committed to seeking these validations to ensure member confidence remain current and innovative:

- The National Committee for Quality Assurance (NCQA) has again accredited all health plans that we submitted for Accreditation during the past cycle.
- Our Behavioral Health care centers nationwide successfully maintained NCQA's Managed Behavioral Healthcare Organization Accreditation.
- We earned Physician Quality (PQ) Certification, which assesses how well a plan provides members with information about doctors and hospitals in its network. Cigna remains the only health plan certified in both hospital and physician.
- The Cigna Group was one of the first health plans (and the first national health plan) to earn NCQA's accreditation for Wellness and Health Promotion. This accreditation remains in place through subsequent cycles and encompasses a wide range of programs (e.g., Health Advisor, Personal Health Team [PHT], lifestyle management, online health coaching).
- Patient and practitioner oriented disease management NCQA accreditation (facilitated by Cigna Behavioral Health) remains in effect for asthma, COPD, congestive heart failure (CHF), coronary artery disease, depression, and diabetes.
- We seek and have successfully retained URAC accreditation for utilization management (since 1991), case management (since 2004), and pharmacy benefit management.

The Cigna Group is one of the most successful, well-managed companies in the group insurance industry:

- We provide medical coverage through managed care and indemnity health care plans to more than 17.0 million people, dental coverage to more than 17.0 million people, behavioral health coverage to approximately 30.3 million people, and pharmacy coverage to approximately 76.0 million people.
- We offer a national HMO network with approximately 2,100 hospitals, 481,000 primary and specialty care doctors, and 29,700 other health care providers and facilities.
- Our company offers a national POS network with approximately 4,400 hospitals, 847,500 primary and specialty care doctors, and 50,600 other providers and facilities.
- We offer a national Open Access Plus (OAP) network with approximately 6,300 hospitals, 1,018,000 primary and specialty care doctors, and 67,700 other providers and facilities.
- Our company offers a national PPO network with approximately 6,300 hospitals, 1,029,000 primary and specialty care doctors, and 67,000 other providers and facilities.

- We offer one of the largest dental networks in the US with more than 320,000 dentist access points.
- The Cigna Group is the first national health service company to provide live customer service 24 hours a day, 7 days a week, 365 days a year.

Local Office Location
1571 Sawgrass
Corporate Pkwy
Sunrise, FL 33323

CIGNA HEALTH AND LIFE INSURANCE COMPANY
CIGNA HEALTH AND LIFE INSURANCE COMPANY

attn Tax Dept - C6tax
900 COTTAGE GROVE RD
HARTFORD, CT 06152-0001

DETACH HERE AND DISPLAY RECEIPT IN A CONSPICUOUS PLACE

CITY OF CORAL GABLES, FLORIDA

LOCAL BUSINESS TAX RECEIPT

THIS IS NOT A BILL-DO NOT PAY

CUST. NO. 191741
RECEIPT NO.
BT-0025000022

2023-2024

BUSINESS NAME: CIGNA HEALTH AND LIFE INSURANCE COMPANY
DBA NAME: CIGNA HEALTH AND LIFE INSURANCE COMPANY

LOCATION: VARIOUS LOCATIONS

CLASSIFICATION:	NO. OF UNITS	UNIT DESCRIPTION	AMOUNT PAID: $ 435.30
1 Insurance Carriers			
2			
3			
4			
5			
6			

BUSINESS TAX RECPT RENEWAL

VALID ONLY AT LOCATION ABOVE.
RECEIPT EXPIRES 09/30/2024

** This receipt does not constitute authority to begin operating at this location without a Certificate of Use and Inspection Approval **

Detail by Entity Name

Foreign Profit Corporation
CIGNA HEALTH AND LIFE INSURANCE COMPANY

Filing Information

Document Number	F96000002814
FEI/EIN Number	59-1031071
Date Filed	06/04/1996
State	CT
Status	ACTIVE
Last Event	AMENDMENT AND NAME CHANGE
Event Date Filed	03/24/2010
Event Effective Date	NONE

Principal Address

900 Cottage Grove Road
Bloomfield, CT 06002

Changed: 06/25/2020

Mailing Address

900 Cottage Grove Road
Bloomfield, CT 06002

Changed: 06/25/2020

Registered Agent Name & Address

CHIEF FINANCIAL OFFICER
200 E. GAINES ST
TALLAHASSEE, FL 32399-0000

Name Changed: 03/17/2003

Address Changed: 04/07/2014

Officer/Director Detail

Name & Address

Title Director

BUCKLEY, TIMOTHY
900 Cottage Grove Road
Bloomfield, CT 06002

Title Director

LABONTE, TRACY
900 Cottage Grove Road
Bloomfield, CT 06002

Title Director, CFO

ROTTKAMP, JOHN
900 Cottage Grove Road
Bloomfield, CT 06002

Title Director

RUSSELL, DAVID
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Bloomfield, CT 06002

Title Director

SNOW, CHRISTOPHER
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Title VP

ABATE, ANTHONY
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BOWE, CHRISTOPHER
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Title VP

CASTELLVI, CHRISTINE
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Bloomfield, CT 06002

Title VP

CETTI, WILLIAM
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Title VP

CHUCHRO, PETER
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CROOKE, STEVEN
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CULP, GARY
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Title VP

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EVELYN, BONNIE
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FITZPATRICK, JAMES
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Title VP

FLEMING, MARK
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Title VP

FUNDERBURK, KIMBERLY
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Title VP

GRAY, RICHARD
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Bloomfield, CT 06002

Title VP

HART, JOANNE
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Title VP

HINMAN, LINDY
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Title VP

HOLGERSON, BRYAN
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Title VP

HOLZLI, TIMOTHY
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Bloomfield, CT 06002

Title VP

HOPKINS, LORI
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Title VP

II, MATTHEW TOTTERDALE
900 Cottage Grove Road
Bloomfield, CT 06002

Title VP

JEFFREYS, MARC
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Title VP

JOHNSON, ROBERT
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JORDAL, KRISTIN
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Title VP

JOSEPHS, M.D., SCOTT
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Title VP

KENYON, MATTHEW
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Title VP

KHAN M.D., M.M., ASLAM
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Title VP

KOBUS, DAVID
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Title VP

KOCHER, RYAN
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Title VP

KRUPP, TARA
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Bloomfield, CT 06002

Title VP

LAMBERT, SCOTT
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Title VP

LEWIS, EDWARD
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Title VP

LIPSON, GREG
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Title VP

MARTINEZ, ERIC
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Title VP

MAZLISH, LEONARD
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Title VP

MIRABELLA, MORRIS
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Bloomfield, CT 06002

Title VP

NEMECEK, DOUGLAS
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Title VP

OCHAL, MARK
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Bloomfield, CT 06002

Title VP

O'NEIL, KATHLEEN
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Bloomfield, CT 06002

Title CHIEF MEDICAL OFFICER

JOSEPHS, M.D., SCOTT
900 Cottage Grove Road
Bloomfield, CT 06002

Title Secretary

MORROW, ALICIA
900 Cottage Grove Road
Bloomfield, CT 06002

Title Treasurer

LAMBERT, SCOTT
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Bloomfield, CT 06002

Title Asst. Secretary

WILLIAMS, ROSINA
900 Cottage Grove Road
Bloomfield, CT 06002

Title Asst. Secretary

WEGRZYNIAK, HEATHER
900 Cottage Grove Road
Bloomfield, CT 06002

Title Asst. Secretary

UNNERSTALL, CHRISTOPHER
900 Cottage Grove Road
Bloomfield, CT 06002

Title Asst. Secretary

TULLOCH, KIMBERLY
900 Cottage Grove Road
Bloomfield, CT 06002

Title Asst. Treasurer

WARFORD, ELIZABETH
900 Cottage Grove Road
Bloomfield, CT 06002

Title Asst. Treasurer

HART, JOANNE
900 Cottage Grove Road
Bloomfield, CT 06002

Title Asst. Treasurer

FLEMING, MARK
900 Cottage Grove Road
Bloomfield, CT 06002

Annual Reports

Report Year	Filed Date
2023	03/11/2023
2023	04/06/2023
2024	04/30/2024

Document Images

04/30/2024 -- ANNUAL REPORT	View image in PDF format
04/10/2023 -- AMENDED ANNUAL REPORT	View image in PDF format
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04/15/2015 -- ANNUAL REPORT	View image in PDF format
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02/09/2012 -- ANNUAL REPORT	View image in PDF format
03/08/2011 -- ANNUAL REPORT	View image in PDF format
05/17/2010 -- ANNUAL REPORT	View image in PDF format
03/24/2010 -- Amendment and Name Change	View image in PDF format
07/17/2009 -- ANNUAL REPORT	View image in PDF format
01/21/2008 -- ANNUAL REPORT	View image in PDF format
03/13/2007 -- ANNUAL REPORT	View image in PDF format
03/09/2006 -- ANNUAL REPORT	View image in PDF format
01/18/2005 -- ANNUAL REPORT	View image in PDF format
07/07/2004 -- ANNUAL REPORT	View image in PDF format
05/05/2003 -- ANNUAL REPORT	View image in PDF format
03/27/2002 -- ANNUAL REPORT	View image in PDF format
02/13/2001 -- ANNUAL REPORT	View image in PDF format
06/07/2000 -- ANNUAL REPORT	View image in PDF format
11/23/1999 -- Name Change	View image in PDF format
05/04/1999 -- ANNUAL REPORT	View image in PDF format
02/19/1998 -- ANNUAL REPORT	View image in PDF format
09/17/1997 -- ANNUAL REPORT	View image in PDF format
06/04/1996 -- DOCUMENTS PRIOR TO 1997	View image in PDF format
06/04/1996 -- Foreign Qualification	View image in PDF format

Florida Office of Insurance Regulation

CIGNA HEALTH AND LIFE INSURANCE COMPANY

Is hereby authorized to transact insurance in the State of Florida.

This certificate signifies that the company has satisfied all requirements of Florida Insurance Code for the issuance of a Life And Health Insurer Certificate Of Authority and remains subject to the laws of Florida.

Date of Issuance: February 17, 1964

No. 10 - 591031071

Kevin M. McCarty
Commissioner
Office of Insurance Regulation

Company Directory: Search Results

This information is current as of 6/19/2024

CIGNA HEALTH AND LIFE INSURANCE COMPANY

FEIN	59-1031071
Florida Company Code	05404
NAIC Company Code	67369
Company Type	LIFE AND HEALTH INSURER
Home State	CT
Web Site	http://WWW.CIGNA.COM
Authorization Type	CERTIFICATE OF AUTHORITY
Authorization Status	ACTIVE
First Licensed in Florida Date	02/17/1964

Addresses

Type	Address	Phone
ADMINISTRATIVE	900 COTTAGE GROVE ROAD, BLOOMFIELD CT 06002 United States	(860) 226-6000
HOME	900 COTTAGE GROVE ROAD, BLOOMFIELD CT 06002 United States	
MAILING	1601 CHESTNUT STREET TL14A, PHILADELPHIA PA 19192 United States	(215) 761-6810
CLAIMS WEBSITE	http://www.cigna.com	0No Phone
LOCATION OF RECORDS	900 COTTAGE GROVE ROAD, BLOOMFIELD CT 06002 United States	(860) 226-6000

Authorized Lines of Business

Line of Business	Type

VARIABLE ANNUITIES	DIRECT AND REINSURANCE
CREDIT DISABILITY	DIRECT AND REINSURANCE
VARIABLE LIFE	DIRECT AND REINSURANCE
CREDIT LIFE	DIRECT AND REINSURANCE
DISCOUNT MEDICAL PLAN	DIRECT AND REINSURANCE
GROUP LIFE AND ANNUITIES	DIRECT AND REINSURANCE
ACCIDENT AND HEALTH	DIRECT AND REINSURANCE
LIFE	DIRECT AND REINSURANCE

New Search

DISCLAIMER

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The inclusion of, or linking to, other web site URLs does not imply our endorsement of, nor responsibility for, those web sites, but has been done as a convenience to our Web site visitors.

EXAMPLES

The Office of Insurance Regulation company search does not require you to know exactly how Office of Insurance Regulation has the company's name recorded. It will take your input and return every name that contains your input as it appears in any part of all records. In other words, if your search is:

Floricorp

then the search will return all the names that have "Floricorp" in any part of the record. For example:

FLORICORP, INC.
FLORICORP PROPERTY AND CASUALTY COMPANY
SOUTHERN FLORICORP UNLIMITED

If you entered

Floricorp P

you would get only

FLORICORP PROPERTY AND CASUALTY COMPANY

Note that even though the whole name is searched, the service still looks for an exact match. So if you entered

FLORICORP,

(i.e., with a comma) you would only get

FLORICORP, INC.

Office of Insurance Regulation

200 East Gaines Street
Tallahassee, Fl 32399
(850) 413-3140

Office of Insurance Commissioner

Healthy employees = Healthy organization

Thank you for this opportunity. We're excited to show what makes Cigna Healthcare the right partner for the City of Coral Gables. And not just your health partner, your growth partner too. When your employees are healthy and thriving, your organization follows suit.

Cigna, through its predecessor companies, has been in the insurance field for more than 200 years. Today, Cigna companies comprise one of the nation's leading providers of health care coverage and insurance plan coverages for businesses and members worldwide. We understand employees in the education and public sector face unique challenges. We know that 65% of public sector employees feel burnt out, compared to only 44% of workers in the private sector. That burnout can lead to physical and emotional health challenges and lost on-the-job growth and productivity as well.

That's why we're invested in solutions that meet the unique needs of the education and public sector industry. Through data-driven technology and innovation, we can tailor well-being recommendations to each of your employees. It's also why we prioritize whole-person health and value-based care within all of our plans. So each individual – and your workforce as a whole – feels valued and supported. And your organization feels poised for healthier growth.

For years, Cigna has been providing health plans to America's local governments, colleges and universities and school districts and has strong, deep connections in Florida. We currently serve 210 Government & Education clients and 520,607 members.[1]

We're committed to helping you achieve your goals by offering the following:

- **Fully Insured Medical Plan Options – Matching Current Plans with Alternates**
- **Employee Assistance Program**

Offer highlights:

- $100,000 Wellness Fund
- Performance Guarantees for Service and Implementation
- Smart Support 24/7/365 with live customer service
- MDLIVE dedicated virtual provider
- Integrated Well-Being Solution Platform - Core Plus package with Incentive Program Option

1. Based on Cigna Book of Business as of March 2024.

Offered by Cigna Health and Life Insurance Company or its affiliates.

Serving those who serve in the public sector

Public sector employees serve people at the local level. At Cigna Healthcare, we do the same. We're dedicated to promoting the health and well-being of the City's employees and their families. Our integrated benefits and scalable outreach programs are designed to educate, engage, and support local government, K-12 and higher education customers with the goal of making a difference in people's lives and driving positive outcomes.

We partner with you to:

- Develop flexible, customized solutions based on your employees' unique needs.
- Provide more effective support with the help of local account teams.
- Keep employees engaged through personalized and digital experiences.

3.3 million

customers in local governments, school districts, colleges and universities[1]

Driving actions and results with our digital-first approach.

For your employees:

We make it easier for your employees to access the care and support they need, right when they need it..

- Multi-touch campaigns to increase awareness of our helpful tools
- Data-driven next-best action steerage to help improve health
- A comprehensive digital experience on myCigna.com, featuring:
  - A personalized dashboard to help better manage claims and maximize benefits
  - Guided search functionality, driving to higher-quality, more-cost-effective providers
  - Complete provider profiles that include diversity and inclusion indicators
  - Seamless access to all digital solutions

For you:

We make things easier for you too, offering peace of mind that employees are becoming healthier and more engaged.

- Detailed reporting on claims, health care costs, utilization and digital engagement
- Intuitive administrative tools designed to make it simpler to manage your plan

Customers who engage with our digital tools are over

40%

more likely to choose recommended, high-quality providers when looking to find care[1]

1. Cigna Book of Business, December 2022

Offered by Cigna Health and Life Insurance Company or its affiliates.

Pharmacy expertise and solutions

Because pharmacy is the #1 driver of health care costs.[1]

With real-time, integrated data and 30+ years of insights, we are uniquely able to help you solve for cost drivers impacting your total medical costs.

Our commitment to you

- **Managing costs** by being at the forefront of trends with more advanced solutions that proactively manage costs
  - **$6,438 per member per year (PMPY)** savings for those we engage who take specialty drugs[2]
- **Empowering and engaging your employees** through technology and integrated care
  - **25%** more engaged in medical case management and behavioral coaching[2]
- **Protecting your investment** in your employees and driving better health outcomes
  - Compelling clinical performance guarantees hold us financially accountable for improving performance

Behavioral health solutions

Expertise, agility and a continued commitment to whole health.

The world has changed. And so have your employees' behavioral health needs. With nearly 45 years of experience in the behavioral health space, Cigna can help.

By continuing to adapt our solutions, we stay relevant to the evolving needs of your employees, helping them stay emotionally well and thriving. This employee-centric, real-time engagement approach delivers better outcomes and more savings.

What we offer:

- 24/7/365 clinical support, including crisis support
- An integrated clinical platform to identify and engage customers earlier
- Doubled network size in the last five years[3] to ensure access to care – including EAP
- 110K+ virtual providers[3], the largest virtual network in the country
- Access to our expertise through our specific Centers of Excellence[4]
- Predictive modeling that finds those at risk and helps them find the right care

39%

of crisis calls come in "after hours"[5]

MDLIVE for Cigna®

talkspace

alma

headspace

Brightside

EQUIP

Bicycle Health

Increasing access with an integrated clinical platform

60% employees don't even seek care – but with our integrated model, we get ensure more people access the care they need. We do this through:

- A diverse provider base
- Digital tools outside of just meeting with a doctor

Employee Assistance Program (EAP) service:

- Three face-to-face visits with an EAP counselor[6], unlimited telephonic consultation, on demand online seminars, home life referrals and other services.
- Access to legal, identity theft and financial consultation services.[7,8]

1. Cigna internal analysis of 2019 commercial claim data. 2. Cigna 2020 Book of Business study of medical customers with integrated medical, pharmacy and total behavioral health vs. those with Cigna medical and carved-out pharmacy. Results may vary. 3. Internal unique provider data as of November 2022. Subject to change. 4. The Cigna Center of Excellence designation is a partial assessment of quality and cost-efficiency and should not be the only basis for decision-making (as such measures have a risk of error). Individuals are encouraged to consider all relevant factors and talk with their physician about selecting a health care facility. Quality designations and ratings found in Cigna's online provider directories are not a guarantee of the quality of care that will be provided to individual patients. Providers are solely responsible for any treatment provided and are not agents of Cigna. 5. 2020 Cigna Behavioral Operations report. Subject to change. 6. Cigna Satisfaction Survey, Employee Assistance Program Evaluation, 2021. Results are gathered throughout the year on a statistically significant sample of National and Regional clients who utilized EAP services. Results may vary.

Access to care and provider collaboration

When it comes to network choice and quality providers, our experience matters.

We deliver programs that focus on quality care and affordability by identifying overuse and directing care to more-efficient care sites while maintaining the same quality. And we continue to lead the way in value-based care innovation with over a decade of experience and commitment to collaboration.

Cigna's approach is different:

- **Quality care:** We focus on coordinated, efficient care to improve health outcomes and avoid unnecessary costs.
- **The right guidance:** We make it easy to find our highest-quality providers by directing your employees to the right care (virtual, digital, 24/7/365 live, chat, clinical outreach).
- **The right access:** We identify the higher-quality, lower-cost doctors and build strong provider networks and virtual care options around them.[1]

Provider collaboration

We work with providers to continuously promote improved performance and expand our network of quality providers. We help providers to deliver exceptional care through:

- Actionable patient insights that are pushed to providers daily
- Aligned interests around employee health, working to address their specific needs
- Coordination by a nurse in the provider's office to promote better outcomes

A range of network options are available to meet your benefit objectives, all designed to offer value, choice and access to quality care. All our offerings - from our broad, nationwide network to high-performing and local network options - include access and guidance to the most efficient health care providers.

650+

Cigna Collaborative Care partnerships[2]

73%

Performed better than market for inpatient admissions[2]

76%

performed better than market for avoidable ER visits[2]

1. Cigna provides access to virtual care through participating in-network providers. Not all providers have virtual capabilities. Cigna also provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas. 2. Cigna internal analysis of existing 2021 arrangements as of August 2022. Subject to change. 3. Program only available for clients with Cigna Dental and Medical. 4. Not available to residents of Texas

Offered by Cigna Health and Life Insurance Company or its affiliates.

Expert client management team

With Cigna, you have a strategic partner to support Broward College. Our expert team is dedicated to understanding the unique needs of your organization, developing a tailored approach to deliver on your goals and objectives. Performance analytics and insights, combined with the knowledge of our experienced team, will guide recommendations to continually improve your cost and the overall health and well-being of your employees.

Your Cigna account management team provide you with comprehensive support and a focus on delivering solutions that strategically align to your goals.

- **Dina D'Angelo**
  Senior Client Manager
- **Joyce Lau**
  Client Account Manager
- **John Kura**
  Client Service Executive
- **Nicole Watson**
  Engagement Consultant
- **Mary Terry-Clines**
  Implementation Manager

Our commitment to you and your employees

It's about people and processes, innovations and insights, and creating a sense of community for our public sector clients and the lives we all serve. Together, we can ensure that everyone has a chance to thrive, thanks in part to our unique and differentiated benefits plans that also help control costs.

Let's work together to help your employees flourish. And your organization grow.

Now is the time to ensure your organization is future proof and ready for whatever comes next.

Through our advocacy solutions, our proven track record of total cost management and our focus on value-based care, we're confident in our ability to help your employees and your organization thrive.

We look forward to continued discussions and, once again, thank you for this opportunity.

AM Best Rating Services

Cigna Health and Life Insurance Company

BestLink **AMB #: 006871 NAIC #: 67369 FEIN #: 591031071**

Mailing Address
1601 Chestnut Street TL14A
Philadelphia, Pennsylvania 19192
United States

Web: www.cigna.com
Phone: 860-226-6000
View Additional Address Information

AM Best Rating Unit: AMB #: 020439 - Cigna Life & Health Group

Assigned to insurance companies that have, in our opinion, an excellent ability to meet their ongoing insurance obligations.

View additional news, reports and products for this company.

Based on AM Best's analysis, 044026 - The Cigna Group is the **AMB Ultimate Parent** and identifies the topmost entity of the corporate structure. View a list of operating insurance entities in this structure.

Best's Credit Ratings

Financial Strength View Definition

Rating (Rating Category):	A (Excellent)
Affiliation Code:	g (Group)
Outlook (or Implication):	Stable
Action:	Affirmed
Effective Date:	April 25, 2024
Initial Rating Date:	June 30, 1976

Long-Term Issuer Credit View Definition

Rating (Rating Category):	a+ (Excellent)
Outlook (or Implication):	Stable
Action:	Affirmed
Effective Date:	April 25, 2024
Initial Rating Date:	September 15, 2010

Financial Size Category View Definition

Financial Size Category:	XV (Greater than or Equal to USD 2.00 Billion)

Best's Credit Rating Analyst

Rating Office: A.M. Best Rating Services, Inc.

Senior Financial Analyst: Jennifer Asamoah

Director: Bridget Maehr

Note: *See the Disclosure information Form or Press Release below for the office and analyst at the time of the rating event.*

Disclosure Information

Disclosure Information Form
View AM Best's Rating Disclosure Form

Press Release
AM Best Affirms Credit Ratings of The Cigna Group and Its Subsidiaries
April 25, 2024

u Denotes Under Review Best's Rating

Rating History

AM Best has provided ratings & analysis on this company since 1976.

Financial Strength Rating

Effective Date	Rating
April 25, 2024	A
May 17, 2023	A
June 22, 2022	A
March 25, 2021	A
February 26, 2020	A

Long-Term Issuer Credit Rating

Effective Date	Rating
April 25, 2024	a+
May 17, 2023	a+
June 22, 2022	a
March 25, 2021	a
February 26, 2020	a

Best's Credit & Financial Reports

Best's Credit Report - financial data included in Best's Credit Report reflects the data used in determining the current credit rating(s) for AM Best Rating Unit: AMB #: 020439 - Cigna Life & Health Group.

Best's Credit Report - Archive - reports which were released prior to the current Best's Credit Report.

Best's Financial Report - financial data included in Best's Financial Report reflects the most current data available to AM Best, including updated financial exhibits and additional company information, and is available to subscribers of Best's Insurance Reports.

Best's Financial Report - Archive - reports which were released prior to the current Best's Financial Report.

View additional news, reports and products for this company.

Press Releases

Date	Title
Apr 25, 2024	AM Best Affirms Credit Ratings of The Cigna Group and Its Subsidiaries
May 17, 2023	AM Best Upgrades Issuer Credit Ratings of The Cigna Group and Most of Its Subsidiaries
Jun 22, 2022	AM Best Revises Issuer Credit Rating Outlook to Positive for Cigna Corporation and Most of Its Subs; Affirms Credit Ratings
Mar 25, 2021	AM Best Affirms Credit Ratings of Cigna Corporation and Its Subsidiaries
Feb 26, 2020	AM Best Affirms Credit Ratings of Cigna Corp and Most Subs; Upgrades Ratings of Medco Containment and Cigna HealthSpring Subs
Jan 04, 2019	AM Best Affirms Credit Ratings of Cigna Corp and Subs; Removes from Under Review, Affirms Ratings of Medco Containment Group

1 2 Page size: 10 20 items in 2 pages

The Cigna Group is a global health service leader focused on improving the health and health outcomes of the people we serve. We deliver choice, predictability, affordability, and access to quality care through integrated capabilities and connected, personalized solutions that advance whole person health. All products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company (CGLIC), Evernorth companies or their affiliates, and Express Scripts companies or their affiliates. Such products and services include an integrated suite of health services, such as medical, dental, behavioral health, pharmacy, vision, supplemental benefits, and other related products.

With a heritage of over 200 years, we now have over 68,000 employees serving our clients and members in more than 30 countries and jurisdictions around the world. Cigna services 170 million members worldwide, with 3.1 million in the US Public Sector. Working together with our members allows us to help them lead healthy, secure lives, provide personally relevant products and services, and help them choose quality health care and achieve optimal health outcomes.

We are confident in our ability to continue to service the needs of the City. We have been offering health plans to America's local governments and educational institutions for more than 200 years, and through our specialized government and education team, we currently serve more than 3.1 million members.

We have strong, deep connections in Florida and provide coverage to a total of 210 government and education clients and 520,607 members in that area and have provided references in Attachment A to reflect our experience with agencies similar in size to the City. Our specialized team will continue to help the City design cost-effective, personalized coverage solutions that connect employees to the programs, services, and health care providers they need to adopt healthier lifestyles.

We accomplish this through

- personalized health and wellness solutions;
- customized employee engagement tools and resources;
- easy, helpful, and convenient specialized customer service and a specialized, highly trained multidisciplinary team;
- integrated solutions to support employees' total health and well-being; and
- a focus on health equity.

We are committed to continue to provide a customized health and wellness solutions that are relevant and effective for each local government, school district, and higher education institution we serve.

We continue to embrace the opportunity for our specialized account management team to become an extension of the City's HR team. Led by Dina D'Angelo, your current senior client manager, the team will support the City beginning at the notification of sale throughout the term

of the contract. In addition to managing the account management team and servicing the account, Dina is responsible for the City's satisfaction with the Cigna partnership. She will consult with the City about the financial performance of the plan, strategy, utilization, and service. The team will collaborate with the City's staff to provide coverage review, communication strategy, long-term wellness strategy, and onsite support for open enrollment meetings and wellness events as well as ongoing employee communications and education throughout the year. Dina will provide onsite office hours on a regular schedule that is mutually acceptable to the City and Cigna.

The account management team incorporates a global team approach to continue to effectively support the City's HR team. We provide designated resources for customer service, accounting, and claims as well as underwriting expertise that translates to exceptional service delivery, focused on building processes and tools to best meet the City's needs.

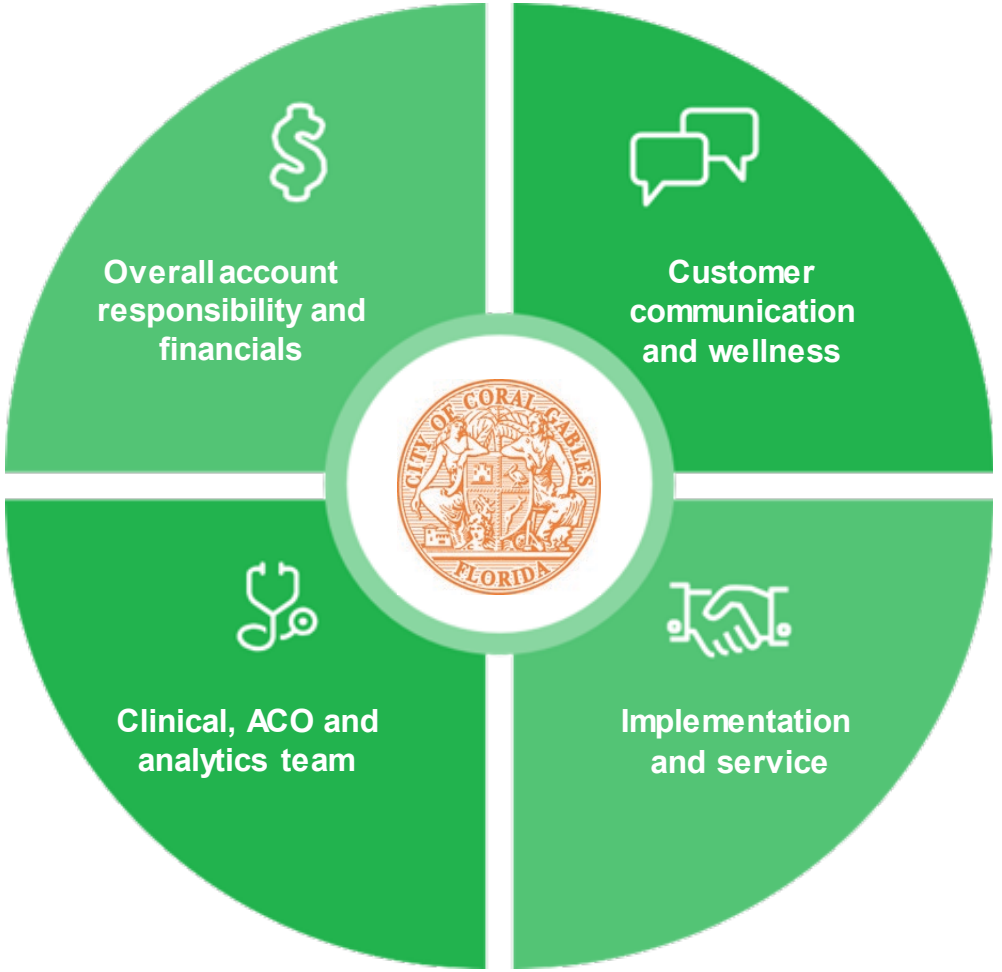
Furthermore, the City will continue to be supported by the Cigna Smart Support Program which includes a specialized customer service team, located throughout the US, that will provide support for the City's employees. This team is exclusively designed to help local government and education members balance a healthy lifestyle with health care costs.

City of Coral Gables Dedicated Cigna Team

Behind you every step of the way.

- **Dina D'Angelo**
  Senior Client Manager
- **Joyce Lau**
  Client Account Manager

- **Dr. Marco Vitiello**
  Senior Medical Executive
- **Stu Rosenthal**
  AVP, Provider Network Management & ACO
- **Rick Pryce**
  Client Informatics
- **Rachel Gomez**
  Pharmacy Account Executive



- **Nicole Watson**
  Engagement Consultant

- **Mary Terry-Clines**
  Implementation Manager
- **John Kura**
  Client Service Executive

Yesenia Sanchez
Market Growth Leader
Executive Sponsor

Resume

1571 Sawgrass Corporate Parkway
Suite 300
Sunrise, FL 33323
954-790-8152

Dina D'Angelo
Senior Client Manager
South Florida Market

As a Senior Client Manager, Dina is responsible for renewal of accounts, service team supervision, renewal strategy discussions with clients and brokers, financial and claims experience reporting. Dina also participates in new account installation and finalist presentations.

Dina D'Angelo joined Cigna in April 2006. She has over 25 years of experience in the healthcare industry. She has held positions in Provider Relations, Contracting and Client Management with Tenet, HCA, United and now Cigna. Her book of business consists of middle market municipality business in the State of Florida.

Dina holds an insurance license in the State of Florida and a Bachelor of Science Degree in Business.

Resume

1571 Sawgrass Corporate Parkway
Suite 300
Sunrise, FL 33323
954-514-6767

Joyce Lau
Client Account Manager
South Florida Market

Joyce Lau is a Client Account Manager based in the Cigna office in Sunrise, Florida. In this role, she partners closely with the Client Manager to ensure best-in-class service delivery and customer satisfaction. Her responsibilities include renewal implementation, client reporting and working closely with departments across the organization to address and resolve operational concerns impacting client satisfaction.

Joyce joined Cigna in February 1998 and have 24 years of experience in the healthcare industry. Prior to her Client Account Manager role, Joyce held the position of Dental Sales Manager and focused on new business sales for the Florida and Caribbean markets.

Joyce also spent seven years in Dental Underwriting in various capacities as a Financial Underwriter to Regional Director. Her extensive knowledge in underwriting serves as an asset to the Cigna HealthCare Sales organization.

Joyce holds an insurance license in the State of Florida and a Bachelor of Science Degree in Finance from Florida International University.

Resume

John.Kura@Cignahealthcare.com
Office 860.787.7911

John Kura
Client Service Executive
Client Installation and Service
Cigna HealthCare

John Kura is a Client Service Executive (CSE) responsible for delivering superior service to his Cigna clients. In the CSE role, John serves as the primary service contact. He is a key member of the account management team with ownership and accountability for ongoing end-to-end service delivery, ensuring your satisfaction with Cigna's products and services, and delivering upon an exceptional client service experience.

John represents, owns, and manages all areas of operational service as it relates to the successful administration of your plan. He will be your primary Cigna contact for all operational service related to claim processing, customer service, eligibility, billing, banking, and benefit administration. These primary functions include customizing service delivery to meet your needs, researching service inquiries, and negotiating with partners and customers, both internal and external, to resolve service issues and requests. He will proactively review service activities, act as a key benefit resource expert, monitor ongoing processes, develop service plans for continuous improvement, and communicate with you on a regular basis regarding service strategy and results on your account.

John began his career with Cigna in 2013 as a Customer Service Advocate, holding several roles with increasing responsibility and complexity until transitioning to the CSE role in 2022.

Resume

Mary Terry-Clines
Implementation Manager

Mary Terry-Clines is an Implementation Manager (IM) based in Chattanooga, TN**.** Mary began her healthcare career at BlueCross BlueShield of Tennessee working in claims, customer service and underwriting prior to moving over to Cigna. Over her 16 years with Cigna, Mary has worked as an Underwriter, Client Service Executive, and Implementation Manager for all segments. She is a key member of your account management team with expertise in Cigna's administration capabilities and overall setup of your account. Mary takes pride in ensuring your satisfaction with Cigna's products, services and delivering an exceptional client experience.

Mary will be your primary contact during the Implementation process. Her primary responsibilities include managing the initial implementation and subsequent plan changes made on Cigna's claim platforms. Mary leads multi-functional teams to include Benefits, Structure, Eligibility, ID Cards, Claims and Member Services. In addition, she coordinates the creation of employee SPD/benefit booklet drafts and ensures client satisfaction through quality and timeliness of service delivery.

Mary is a very approachable person. She believes in the philosophy that we have to help each other in order for all to succeed!

Resume

Nicole Watson
Client Engagement Manager

As Client Engagement Manager (CEM) Nicole will be a dedicated resource responsible for the execution and delivery of Health and Wellness strategy to ensure that both you and your employees have an outstanding customer service experience. In her role as Health and Wellness resource, Nicole will provide reporting and partner with clients throughout the year to provide insight into trends and identify health and wellness opportunities. She will support, develop, and facilitate client Health and Wellness programs, assist with coordination of events, consult on development of a communication plan, and help to promote education initiatives ensuring that employees are knowledgeable about the CIGNA Health and Wellness tools and capabilities. In addition, Nicole will assist with Open Enrollment strategy and execution, both at implementation and renewal.

Nicole is dedicated to wellness strategy and execution of initiatives, as well as open enrollment and customer education. She has over seven years of experience in Human Resources (Benefits Administration), and Health & Benefits consulting.

EDUCATION: Florida Atlantic University, Boca Raton, Florida

Resume

rachel.gomez@cignahealthcare.com

O: 860.907.0888

Rachel Gomez, GBA

Pharmacy Account Executive (PAE)

As a Cigna PAE, Rachel serves as a pharmacy consultant partner to clients and brokers/advisors. In her role, she is charged with client retention, assisting with negotiating pharmacy renewals, and explaining current pharmacy trend and client spend. By introducing innovative and integrated Cigna pharmacy product offerings to clients, she plays a key role in helping lower their pharmacy trend, and delivering affordable and competitive pharmacy benefits to their members.

Rachel has worked in the health care industry for nearly 11 years. Before joining Cigna in 2021, she worked at a global employee benefits and risk management firm. Rachel has experience managing and serving mid-size clients in the manufacturing, tourism/hospitality, technology, healthcare, financial, retail/wholesale, government, and education sectors.

Cigna will continue to administer an extensive program that offers the City's members incentives for activities and health advocacy program completion based on client-specific parameters while surrounding them with value- based coverage options appropriate to their medical condition.
Our belief and current experience is that the most effective applications of value-based design are those that apply across entire populations. These include the following:
•Generic preventive drugs for certain conditions have 100 percent coverage with no deductible. Prescription drug list steerage toward generic replacement alone supports the ROI for this.
•Preventive care has 100 percent coverage with no deductible. This is standard on our medical plans.
•For high-performing specialists, there are reduced copays in our tiered benefit solution, Cigna Tiered Benefits. In-network PCPs and specialists are placed in a preferred coverage tier based on evidence-based quality indicators. This program demonstrates our proven ability to improve both clinical quality and cost measures.
•There are reduced or no copays for preferred labs and radiology procedures.

Our approach to value-based plan design includes a holistic solution using a combination of targeted incentives to improve health risk awareness, targeted coaching, and plan design solutions. With this approach, the City can elect to link incentives to a variety of our health advocacy programs.

Better health isn't just a goal, it's essential to the vitality of your workforce. We're giving your employees the tools they need to be their best through our **new Cigna Healthcare℠ Well-Being Solution.**

The holistic and personalized **Well-Being Solution** will provide a personalized, best-in-class experience to help individuals make small, everyday changes to their well-being focused on areas that they want to improve the most. Available in over 21 languages and seamlessly connected via myCigna, our innovative platform includes the following features that work in concert with one another:

- an expansive, evidence-based educational content library with various health topics that include getting active, eating healthy, sleeping well, reducing stress, finding emotional balance, and Coronavirus support;
- approximately 1,300 digital cards that help improve well-being literacy and inspire new behaviors with micro-learning content;
- AI-driven recommendations designed to reinforce more than 115 healthy habits;
- health risk assessment and survey tools, certified by the National Committee for Quality Assurance (NCQA);
- peer-to-peer well-being challenges;
- device integration with any device, app, or tracker that connects to Apple® Health app or Google Fit®;
- social connections, allowing members to invite up to 10 family members/friends to share in the experience;
- a total of 25 digital health coaching journeys that help members improve their health literacy and form new habits naturally; and
- automated communications and engagement campaigns.

When the City's employees utilize the program over time, they build healthy habits, have fun with friends and family, and experience the lifetime rewards of better health and well-being.

We pair this offering with our team of highly trained health engagement consultants who are available to work personally with the City to build holistic and inclusive health engagement strategies beyond the traditional dimensions of well-being. We leverage actionable insights from social determinants of health

data, analytics from claims, biometrics, health assessments, and interaction data to guide data-driven decisions and ensure a highly personalized plan. Member tools and resources allow the City's employee population to see measurable results. Together, we will help guide your employees to a healthier way of life, and our team of experts can help the City increase the health engagement of the population steadily, year after year.

Integration

At The Cigna Group, we recognize that health is the starting point of vitality and where we can make the biggest, measurable impact in peoples' lives. By having a holistic-health view, we want to help you better understand the complexity of employee health and help your employees improve their health and well-being, creating better outcomes and more productivity.

Truly integrated benefits go well beyond just coordinating or bundling benefits, and it starts with one, real-time clinical platform for all our benefits, removing limitations and delays on data feeds and creating actionable insights, proactive and timely member engagement opportunities, and collaboration with providers. Integration of our pharmacy and behavioral health care services with medical allows us to view every step of a member's journey, anticipating needs and engaging each member at the right moments. We understand that addressing physical and mental health simultaneously is critical to improving whole health. Our real-time, connected platforms allow us to intervene and impact important health care decisions for our members without delaying necessary care.

Medical and Pharmacy

For the sixth year in a row, our Value of Integration study shows real engagement and savings. A retrospective analysis—using methodology reviewed and validated by Aon in 2022—continues to demonstrate that connecting medical, pharmacy, and behavioral health care through integrated benefits enables us to support the whole person, better engage our members, and reduce total medical costs for our clients.

When comparing integrated Cigna Healthcare medical, pharmacy, and Cigna Total Behavioral Health to Cigna Healthcare Medical and basic behavioral (i.e., with pharmacy and behavioral carved out), we saw greater savings and health improvement opportunities that are not achieved when benefits are fragmented. Members were actively involved in our chronic condition coaching programs, lifestyle management programs, wellness coaching, or case management. Additionally, they worked to improve their health by completing a health improvement activity such as closing a gap in care, participating in coaching, or obtaining additional treatment decision support.

When members are engaged and stay in the network, clients realize significant savings. With integrated medical, behavioral, and pharmacy benefits, clients see approximately $148 PMPY savings in total medical costs. These savings are seen across our entire population, but when we drill down to those with an identified health improvement activity, we see that total medical cost savings go up to approximately $1,407 PMPY. That savings can increase to $8,907 PMPY when we engage members who take specialty drugs and to $11,397 PMPY when we engage members who take specialty drugs for an inflammatory diagnosis.[1]

With integrated benefits, when a member reaches out, our clinical and service teams are uniquely able to look across all benefits to assess the health status of a member. Pharmacy is typically our first line to engage a member. On average, every member gets at least one prescription each month—and when pharmacy is integrated into medical, the speed with which we can identify and engage our members is critically unique and important. We can inform the member of more affordable treatment options and contact their doctor(s) about preferred alternatives. We can also work with them to find the best location for infusions, when appropriate. Beyond these educational opportunities, we can also address anything else the member is facing, such as a gap in care, common comorbidity, or mental health needs. This 360-degree

view allows us to wrap the member with cost-effective, appropriate care, personalized support, and programs at the right time.

Medical and Cigna Total Behavioral Health

With over 48 years of experience serving as a leader in the behavioral health space, our behavioral health solutions are designed to holistically benefit clients, employees, families, and communities. Behavioral health issues have become increasingly prevalent yet go unaddressed. In fact, 60% of people who suffer do not get care which can lead to decreased productivity, increased absenteeism, turnover, and ultimately higher costs.[2]

Our proprietary data analysis demonstrates that when people diagnosed with a behavioral health condition, such as anxiety, depression, or substance use disorder, receive appropriate behavioral health planning and treatment intervention, medical costs are reduced by up to $2,565 per person in the 15 months post diagnosis.[3]

When we address the basic needs, there is a greater ability to focus on health improvement. We help improve the health and vitality of those we serve by managing issues before they become more serious and by engaging the member using a holistic, integrated approach. This approach includes the following:

- innovative, evidence-based clinical programs focused on reducing the negative impacts of behavioral issues;
- an extensive, national network of behavioral providers and facilities, including a national fast access network, Centers of Excellence, and providers that specialize in treating emergency responders, health care professionals, LGBTQ+, and those members managing racial/ethnic concerns and issues;
- the largest behavioral health virtual network in the country, including national access to digital providers such as Talkspace, Headspace Care (formerly Ginger), Alma, Meru Health, Brightside, and many others;
- a combination of behavioral, wellness, and pharmacy components developed to achieve lasting results, improve health, and reduce total medical costs;
- 24/7/365 live toll-free access to routine care and crisis triage support;
- provider search and match support, appointment scheduling, and new online scheduling options;
- personalized member experience that includes mindfulness, stress management techniques, and ways to combat feelings of loneliness/isolation;
- unlimited in-the-moment consultations sessions lasting for 45 – 60 minutes, providing members the opportunity to speak with a clinical professional immediately and receive information and guidance to address their behavioral health concerns;
- services to help manage life events, which includes in-person, virtual, or Talkspace-based sessions with an EAP counselor, work/life services, and a community support program;
- 100% follow up digitally or telephonically to ensure customer needs are met;
- a clinical navigator assigned to each member with more complex needs, allowing a member to continue to engage with the same clinical navigator throughout their behavioral health journey; and
- a full spectrum of services that support members and their families.

We have established connection points across our medical and behavioral benefits, including an integrated clinical systems platform, a multidisciplinary consult process (which also encompasses pharmacy), predictive modeling using integrated data, and collaboration between medical and behavioral clinicians within many of our medical management and health advocacy coaching programs. These points of connection drive holistic health management and provide opportunities

for intervention and engagement, ultimately improving health and reducing total medical costs for the City and its employees.

(1) Cigna Healthcare 2022 book-of-business study of medical customers with integrated medical, pharmacy and Cigna Total Behavioral Health versus those with Cigna Healthcare medical and carved-out pharmacy. Individual results will vary; not guaranteed. Average annual PMPY and per patient per year.

(2) Harvard Medical School. "Mental Illnesses are Common, but Care is Lacking." Nov. 2019.

Medical Management

Many of our unique advantages can be found in the investment and innovations of our medical management programs. Our Health Matters Care Management Preferred model was designed to better improve the health of our clients' employees and their family members while lowering overall health care costs for everyone.

As with most medical management programs, it includes utilization management, inpatient case management, and case management:

- Utilization management includes precertification of inpatient admissions and of specific categories of outpatient services.
- Inpatient case managers provide inpatient case management (concurrent stay review) in what is primarily a health care provider–facing role, beginning before the presumed discharge date.
- Nurse case managers provide complex and catastrophic case management services; specialty teams provide case management services for transplant, oncology, high-risk maternity, NICU, chronic kidney disease (CKD), advanced cellular therapy, gene therapy, and specialty care options cases.

These services are supported by phone calls, online tools, and services.

Care Management Preferred also includes the following advantages that help differentiate our program from other programs in the marketplace:

- We conduct a higher level of outreach to members in the hospital. We reach out to members before they are admitted to an inpatient facility, when provided with at least four days' notification of the impending admission.
- We conduct postdischarge outreach to hospitalized members who have had a length of stay of three days or longer to confirm that the doctor's treatment plan is in place and to assist with any problems the member may be having following the hospitalization.
- Through rigorous, data-driven health-risk identification, our Health Matters suite of predictive models employs several predictive modeling tools. Our proprietary analytic models help us prioritize outreach and better target members for the right clinical programs. Continually reviewing current and past member data allows us to help predict a likely future health event.

- Our enhanced inpatient identification algorithms provide a real-time assessment during the inpatient stay before claims are generated and help our inpatient case managers identify potential case management candidates as early as possible. The model specifically targets those diagnoses that could lead to a hospital readmission.
- When clients also select our pharmacy and behavioral services, medical, behavioral, and pharmacy clinicians participate in complex case discussions through our integrated multidisciplinary team approach and use their expertise to collaboratively address the cases.
- Our medical directors participate in multidisciplinary rounds and provide increased review of utilization management and support of case management cases.
- With Cigna Pharmacy, our early identification model uses real-time/point-of-sale information to identify potential program participants, even before associated claims are processed.
- The RN case managers use a specialized referral search engine to locate both national and community-based resources. When members' needs are complex, the RN case managers refer them to our community support team clinicians, who are either social workers or other licensed clinicians.
- As part of our goal to provide a consistent, consultative experience for our members no matter how they interact with us, our member-facing clinicians are also part of our One Guide team. They receive

enhanced training and technological tools that equip them to offer even more personalized interactions and exceptional service to members on issues that extend beyond health concerns, such as plan benefits, claim issues, and provider questions.

In summary, our care management solution allows us to
- find members early and proactively and engage them in our programs;
- personalize the experience to each member, because everyone's needs are different;
- connect our members to the right resources for their diagnosis and personal situation;
- help members find and use quality, cost-effective care; and
- approach our members consultatively to better understand their condition and treatment options.

We get to know our members, and we stay connected with them throughout their journey to better health.

Your Health First

Our Your Health First® chronic condition coaching model continues to take a broad approach to helping the City's members manage chronic health conditions. Your Health First addresses the health of the whole person, rather than focusing on a single disease that triggers participation. Supported by evidence-based medical guidelines and influential behavioral techniques, our health coaches help members manage every aspect of their personal health, including adhering to medications, understanding and managing risk factors, and maintaining up-to-date screenings.

Your Health First addresses the most prevalent conditions: heart disease, coronary artery disease, angina, congestive heart failure (CHF), acute myocardial infarction, peripheral arterial disease, asthma, COPD (emphysema and bronchitis), diabetes (types 1 and 2), metabolic syndrome/weight complications, osteoarthritis, low back pain, anxiety, bipolar disorder, and depression. We include anxiety, bipolar disorder, and depression because we understand the importance of the mind-body connection when providing services to members with both medical and behavioral chronic conditions. We also support comorbid conditions through this model.

Our predictive models tap into member data across our integrated plan coverage and systems to identify members with chronic conditions at risk for near-term and future high claim costs. Our models predict a likely condition-related occurrence or a worsening of an existing condition in the upcoming year, prioritize member health risk(s), and predict the optimal outreach modality (phone, email, or text) for each member based on factors such as condition, severity, progression, behavior, and modifiability. We target members identified as higher risk for phone-based coaching. We reach out to those identified as lower risk and/or to those who have an apparent preference for digital engagement by letter and/or email to encourage engagement in the program's self-guided online resources.

We train Your Health First health coaches in the Cigna CARE Coaching® model that features collaborative, affirming, respectful, and empowering coaching. Cigna CARE Coaching is a foundational approach that addresses a variety of medical, behavioral, and lifestyle conditions. Before registering for the Cigna CARE Coaching training, health coaches complete two courses that address behavior coaching. Each health coach then completes a weeklong training course that incorporates features of various proven behavior change models. Using this coaching approach, health coaches assist members with setting specific, attainable goals to help them improve their health. Achievement of these goals motivates members to set new goals that will support them as they continue their journey toward better health.

In addition to coaching for chronic conditions and in support of working with the whole person, Your Health First coaching for members identified with chronic conditions includes health and wellness coaching, treatment decision support, gaps-in-care coaching, and lifestyle management coaching for weight management, stress management, and tobacco cessation.

In summary, our dedicated health coaches focus on each person's unique health needs, preferences, and goals. The health coach's one-on-one approach creates stronger relationships, establishes trust, and drives higher engagement. Combining clinical expertise, evidence-based practices, and extensive

experience, our multidisciplinary health coaches manage health to start behavior change. Specifically, they help members

- recognize worsening symptoms and know when to see a doctor;
- establish questions to discuss with their doctors;
- understand the importance of following doctors' orders;
- develop healthy habits related to nutrition, sleep, exercise, weight, tobacco, and stress;
- prepare for hospital admissions or recovery after hospital stays; and
- make educated decisions about treatment options.

Finally, as part of our goal to provide a consistent, consultative experience for our members no matter how they interact with Cigna, our Your Health First health coaches are also part of our One Guide team. They receive enhanced training and technological tools that equip them to offer even more personalized interactions and exceptional service to members on issues that extend beyond health concerns, such as plan benefits, claim issues, and provider questions. With this role enhancement, our health coaches strive to optimize every touchpoint to help members more deeply engage with their health, and with the most relevant programs and services available to them, driving positive clinical and cost outcomes.

Cigna Network Analysis

Cigna Open Access Plus (OAP)

Created for...

City of Coral Gables

July 2024

Contents

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July 2024

Created for...
City of Coral Gables

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Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

[1] Provider counts represent:
#: Provider access points
P: Unique providers
L: Unique provider locations

Employees With Access

Employee		Provider		With Access		Counts[1]			Average Distance	
Group	#	Group	Standard	#	%	#	P	L	1	2
All Employees	537	Adult Primary Care Physi…	2 in 10 miles	537	100.0	1,021,851	356,372	122,737	0.5	0.6
		Pediatricians	2 in 10 miles	536	99.8	198,662	76,826	35,185	0.8	1.0
		OB/Gyns	2 in 15 miles	537	100.0	160,057	45,174	26,440	1.2	1.3
		Other Specialists	2 in 15 miles	537	100.0	4,483,265	1,281,264	310,003	0.3	0.4
		Hospitals	1 in 20 miles	537	100.0	10,911	6,418	8,945	1.8	2.7
		Laboratories	1 in 20 miles	535	99.6	7,116	1,344	6,477	1.9	2.7
		Urgent Care Facilities	1 in 20 miles	535	99.6	8,831	3,258	7,687	1.5	2.0

Key Geographic Areas

State Name	City	Employee	Provider		With Access		Counts[1]	Average Distance	
		#	Group	Standard	#	%	#	1	2
Florida	Miami	422	Adult Primary Care Physici…	2 in 10 miles	422	100.0	4,837	0.5	0.6
			Hospitals	1 in 20 miles	422	100.0	36	1.6	2.5
			Laboratories	1 in 20 miles	422	100.0	30	1.7	2.3
			OB/Gyns	2 in 15 miles	422	100.0	867	1.2	1.3
			Other Specialists	2 in 15 miles	422	100.0	24,114	0.3	0.3
			Pediatricians	2 in 10 miles	422	100.0	1,011	0.8	0.9
			Urgent Care Facilities	1 in 20 miles	422	100.0	63	1.3	1.7
	Homestead	38	Adult Primary Care Physici…	2 in 10 miles	38	100.0	241	0.8	0.9
			Hospitals	1 in 20 miles	38	100.0	2	2.6	3.2
			Laboratories	1 in 20 miles	38	100.0	1	3.4	7.4
			OB/Gyns	2 in 15 miles	38	100.0	65	1.2	1.3
			Other Specialists	2 in 15 miles	38	100.0	641	0.4	0.5
			Pediatricians	2 in 10 miles	38	100.0	54	1.0	1.1
			Urgent Care Facilities	1 in 20 miles	38	100.0	5	2.6	2.8
	Hialeah	21	Adult Primary Care Physici…	2 in 10 miles	21	100.0	500	0.3	0.4
			Hospitals	1 in 20 miles	21	100.0	6	1.2	1.8
			Laboratories	1 in 20 miles	21	100.0	7	1.2	2.0
			OB/Gyns	2 in 15 miles	21	100.0	51	1.2	1.3
			Other Specialists	2 in 15 miles	21	100.0	1,701	0.3	0.3
			Pediatricians	2 in 10 miles	21	100.0	87	0.6	0.9
			Urgent Care Facilities	1 in 20 miles	21	100.0	11	1.5	1.7
	Hollywood	20	Adult Primary Care Physici…	2 in 10 miles	20	100.0	729	0.5	0.6
			Hospitals	1 in 20 miles	20	100.0	20	1.4	2.3
			Laboratories	1 in 20 miles	20	100.0	11	1.3	1.9
			OB/Gyns	2 in 15 miles	20	100.0	192	0.8	1.0
			Other Specialists	2 in 15 miles	20	100.0	4,586	0.3	0.4
			Pediatricians	2 in 10 miles	20	100.0	245	0.7	1.0
			Urgent Care Facilities	1 in 20 miles	20	100.0	17	1.3	1.9

Access Summary By City (Without Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee Group
All Employees

Provider Group
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

[1] Provider counts represent:
#: Provider access points
P: Unique providers
L: Unique provider locations

Employees Without Access

Employee		Provider		Without Access		Counts[1]			Average Distance	
Group	#	Group	Standard	#	%	#	P	L	1	2
All Employees	537	Pediatricians	2 in 10 miles	1	0.2	198,662	76,826	35,185	4.8	12.3
		Laboratories	1 in 20 miles	2	0.4	7,116	1,344	6,477	34.7	45.8
		Urgent Care Facilities	1 in 20 miles	2	0.4	8,831	3,258	7,687	48.0	74.0

Key Geographic Areas

State Name	City	Employee	Provider		Without Access		Counts[1]	Average Distance	
		#	Group	Standard	#	%	#	1	2
Florida	Key Largo	1	Laboratories	1 in 20 miles	1	100.0	0	22.1	29.9
	Marathon	1	Laboratories	1 in 20 miles	1	100.0	0	47.2	61.7
	Key Largo	1	Pediatricians	2 in 10 miles	1	100.0	1	4.8	12.3
	Pahokee	1	Urgent Care Facilities	1 in 20 miles	1	100.0	0	28.5	29.7
Oregon	Medford	1	Urgent Care Facilities	1 in 20 miles	1	100.0	0	67.4	118.2

Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
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Employees With Access

State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Broward	Fort Lauder…	33317	1	Adult Primary Ca…	2 in 10 miles	74	1	100.0	1.1	1.3
					Pediatricians	2 in 10 miles	28	1	100.0	1.4	1.4
					OB/Gyns	2 in 15 miles	29	1	100.0	1.3	1.3
					Other Specialists	2 in 15 miles	411	1	100.0	1.1	1.1
					Hospitals	1 in 20 miles	0	1	100.0	2.2	3.0
					Laboratories	1 in 20 miles	1	1	100.0	1.3	2.0
					Urgent Care Facil…	1 in 20 miles	3	1	100.0	1.2	1.3
			33323	1	Adult Primary Ca…	2 in 10 miles	14	1	100.0	0.6	0.6
					Pediatricians	2 in 10 miles	18	1	100.0	0.9	0.9
					OB/Gyns	2 in 15 miles	6	1	100.0	1.2	1.6
					Other Specialists	2 in 15 miles	296	1	100.0	0.3	0.5
					Hospitals	1 in 20 miles	0	1	100.0	4.2	5.6
					Laboratories	1 in 20 miles	0	1	100.0	2.6	4.1
					Urgent Care Facil…	1 in 20 miles	1	1	100.0	0.6	2.2
			33324	1	Adult Primary Ca…	2 in 10 miles	315	1	100.0	0.5	0.5
					Pediatricians	2 in 10 miles	191	1	100.0	0.5	0.5
					OB/Gyns	2 in 15 miles	39	1	100.0	0.6	0.6
					Other Specialists	2 in 15 miles	1,543	1	100.0	0.3	0.5
					Hospitals	1 in 20 miles	1	1	100.0	1.0	2.6
					Laboratories	1 in 20 miles	2	1	100.0	1.0	1.3
					Urgent Care Facil…	1 in 20 miles	4	1	100.0	1.2	1.8
			33328	1	Adult Primary Ca…	2 in 10 miles	71	1	100.0	0.8	1.1
					Pediatricians	2 in 10 miles	21	1	100.0	1.4	1.4
					OB/Gyns	2 in 15 miles	57	1	100.0	1.4	1.4
					Other Specialists	2 in 15 miles	553	1	100.0	0.5	0.7
					Hospitals	1 in 20 miles	3	1	100.0	1.1	1.4
					Laboratories	1 in 20 miles	1	1	100.0	1.1	1.5
					Urgent Care Facil…	1 in 20 miles	1	1	100.0	1.1	2.0
			33334	1	Adult Primary Ca…	2 in 10 miles	40	1	100.0	0.6	0.7
					Pediatricians	2 in 10 miles	14	1	100.0	0.9	0.9
					OB/Gyns	2 in 15 miles	5	1	100.0	0.9	0.9
					Other Specialists	2 in 15 miles	373	1	100.0	0.2	0.4
					Hospitals	1 in 20 miles	0	1	100.0	1.1	2.5
					Laboratories	1 in 20 miles	3	1	100.0	0.7	0.9
					Urgent Care Facil…	1 in 20 miles	1	1	100.0	0.7	1.5
			33351	1	Adult Primary Ca…	2 in 10 miles	53	1	100.0	0.3	0.3
					Pediatricians	2 in 10 miles	7	1	100.0	0.3	0.3
					OB/Gyns	2 in 15 miles	0	1	100.0	1.9	1.9
					Other Specialists	2 in 15 miles	204	1	100.0	0.2	0.3
					Hospitals	1 in 20 miles	0	1	100.0	2.8	3.4

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access											
State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Broward	Fort Lauder…	33351	1	Laboratories	1 in 20 miles	0	1	100.0	2.6	3.0
					Urgent Care Facil…	1 in 20 miles	4	1	100.0	1.0	1.0
		Hallandale	33009	1	Adult Primary Ca…	2 in 10 miles	102	1	100.0	0.1	0.2
					Pediatricians	2 in 10 miles	8	1	100.0	0.5	0.5
					OB/Gyns	2 in 15 miles	17	1	100.0	0.1	0.7
					Other Specialists	2 in 15 miles	341	1	100.0	0.1	0.1
					Hospitals	1 in 20 miles	1	1	100.0	0.8	1.2
					Laboratories	1 in 20 miles	0	1	100.0	1.6	3.8
					Urgent Care Facil…	1 in 20 miles	2	1	100.0	0.1	1.2
		Hollywood	33020	1	Adult Primary Ca…	2 in 10 miles	30	1	100.0	0.2	0.3
					Pediatricians	2 in 10 miles	1	1	100.0	0.6	1.6
					OB/Gyns	2 in 15 miles	7	1	100.0	0.8	0.8
					Other Specialists	2 in 15 miles	163	1	100.0	0.2	0.3
					Hospitals	1 in 20 miles	2	1	100.0	0.6	1.4
					Laboratories	1 in 20 miles	1	1	100.0	2.0	2.3
					Urgent Care Facil…	1 in 20 miles	2	1	100.0	0.6	1.4
			33021	1	Adult Primary Ca…	2 in 10 miles	238	1	100.0	0.5	0.6
					Pediatricians	2 in 10 miles	115	1	100.0	0.6	0.6
					OB/Gyns	2 in 15 miles	90	1	100.0	0.6	0.7
					Other Specialists	2 in 15 miles	2,028	1	100.0	0.6	0.6
					Hospitals	1 in 20 miles	10	1	100.0	0.7	0.7
					Laboratories	1 in 20 miles	1	1	100.0	1.1	2.1
					Urgent Care Facil…	1 in 20 miles	3	1	100.0	0.7	1.3
			33023	2	Adult Primary Ca…	2 in 10 miles	22	2	100.0	0.3	0.3
					Pediatricians	2 in 10 miles	1	2	100.0	0.9	1.4
					OB/Gyns	2 in 15 miles	1	2	100.0	1.3	1.8
					Other Specialists	2 in 15 miles	91	2	100.0	0.1	0.1
					Hospitals	1 in 20 miles	0	2	100.0	2.1	2.4
					Laboratories	1 in 20 miles	0	2	100.0	1.7	2.4
					Urgent Care Facil…	1 in 20 miles	0	2	100.0	2.0	2.9
			33025	4	Adult Primary Ca…	2 in 10 miles	14	4	100.0	0.4	0.6
					Pediatricians	2 in 10 miles	11	4	100.0	0.5	0.7
					OB/Gyns	2 in 15 miles	2	4	100.0	0.6	0.6
					Other Specialists	2 in 15 miles	194	4	100.0	0.2	0.3
					Hospitals	1 in 20 miles	2	4	100.0	1.0	1.8
					Laboratories	1 in 20 miles	2	4	100.0	1.1	1.8
					Urgent Care Facil…	1 in 20 miles	4	4	100.0	0.8	1.1
			33026	3	Adult Primary Ca…	2 in 10 miles	86	3	100.0	0.2	0.3
					Pediatricians	2 in 10 miles	43	3	100.0	0.4	0.4
					OB/Gyns	2 in 15 miles	12	3	100.0	0.6	0.7

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access

State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Broward	Hollywood	33026	3	Other Specialists	2 in 15 miles	479	3	100.0	0.2	0.4
					Hospitals	1 in 20 miles	2	3	100.0	1.1	1.1
					Laboratories	1 in 20 miles	1	3	100.0	1.1	1.5
					Urgent Care Facil…	1 in 20 miles	0	3	100.0	0.9	2.1
			33027	7	Adult Primary Ca…	2 in 10 miles	102	7	100.0	0.6	0.7
					Pediatricians	2 in 10 miles	2	7	100.0	0.8	1.3
					OB/Gyns	2 in 15 miles	28	7	100.0	0.8	1.0
					Other Specialists	2 in 15 miles	442	7	100.0	0.4	0.4
					Hospitals	1 in 20 miles	0	7	100.0	1.6	2.8
					Laboratories	1 in 20 miles	2	7	100.0	1.4	2.0
					Urgent Care Facil…	1 in 20 miles	1	7	100.0	1.6	2.2
			33029	2	Adult Primary Ca…	2 in 10 miles	61	2	100.0	1.0	1.0
					Pediatricians	2 in 10 miles	58	2	100.0	1.0	1.1
					OB/Gyns	2 in 15 miles	38	2	100.0	1.4	1.4
					Other Specialists	2 in 15 miles	512	2	100.0	0.3	0.5
					Hospitals	1 in 20 miles	1	2	100.0	2.5	5.0
					Laboratories	1 in 20 miles	3	2	100.0	1.5	1.5
					Urgent Care Facil…	1 in 20 miles	2	2	100.0	1.3	1.5
		Pembroke P…	33028	1	Adult Primary Ca…	2 in 10 miles	94	1	100.0	0.5	0.9
					Pediatricians	2 in 10 miles	14	1	100.0	2.2	2.2
					OB/Gyns	2 in 15 miles	42	1	100.0	1.4	1.8
					Other Specialists	2 in 15 miles	691	1	100.0	0.2	0.4
					Hospitals	1 in 20 miles	4	1	100.0	2.2	2.3
					Laboratories	1 in 20 miles	0	1	100.0	1.8	2.3
					Urgent Care Facil…	1 in 20 miles	1	1	100.0	0.7	1.7
		Pompano B…	33073	1	Adult Primary Ca…	2 in 10 miles	39	1	100.0	0.4	0.5
					Pediatricians	2 in 10 miles	19	1	100.0	1.1	1.1
					OB/Gyns	2 in 15 miles	11	1	100.0	1.0	1.1
					Other Specialists	2 in 15 miles	232	1	100.0	0.1	0.4
					Hospitals	1 in 20 miles	0	1	100.0	3.0	3.7
					Laboratories	1 in 20 miles	2	1	100.0	1.3	1.3
					Urgent Care Facil…	1 in 20 miles	1	1	100.0	1.7	1.8
	Flagler	Palm Coast	32137	1	Adult Primary Ca…	2 in 10 miles	82	1	100.0	1.5	1.5
					Pediatricians	2 in 10 miles	5	1	100.0	2.6	2.6
					OB/Gyns	2 in 15 miles	14	1	100.0	1.6	2.1
					Other Specialists	2 in 15 miles	327	1	100.0	0.6	0.6
					Hospitals	1 in 20 miles	1	1	100.0	2.8	7.2
					Laboratories	1 in 20 miles	2	1	100.0	1.6	1.8
					Urgent Care Facil…	1 in 20 miles	2	1	100.0	1.5	2.5
			32164	2	Adult Primary Ca…	2 in 10 miles	113	2	100.0	2.6	2.7

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access												
State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Flagler	Palm Coast	32164	2	Pediatricians	2 in 10 miles	3	2	100.0	3.1	3.1
					OB/Gyns	2 in 15 miles	3	2	100.0	3.0	3.0
					Other Specialists	2 in 15 miles	283	2	100.0	1.0	1.0
					Hospitals	1 in 20 miles	1	2	100.0	3.2	4.1
					Laboratories	1 in 20 miles	3	2	100.0	3.4	3.7
					Urgent Care Facil…	1 in 20 miles	3	2	100.0	3.1	3.8
	Martin	Stuart	34997	1	Adult Primary Ca…	2 in 10 miles	98	1	100.0	0.4	0.4
					Pediatricians	2 in 10 miles	5	1	100.0	0.6	0.6
					OB/Gyns	2 in 15 miles	5	1	100.0	0.6	0.6
					Other Specialists	2 in 15 miles	517	1	100.0	0.3	0.3
					Hospitals	1 in 20 miles	2	1	100.0	0.6	0.6
					Laboratories	1 in 20 miles	0	1	100.0	4.6	4.6
					Urgent Care Facil…	1 in 20 miles	1	1	100.0	2.2	2.8
	Miami-Dade	Coral Gables	33114	1	Adult Primary Ca…	2 in 10 miles	0	1	100.0	0.1	0.2
					Pediatricians	2 in 10 miles	0	1	100.0	0.2	0.6
					OB/Gyns	2 in 15 miles	0	1	100.0	0.2	0.2
					Other Specialists	2 in 15 miles	0	1	100.0	0.1	0.1
					Hospitals	1 in 20 miles	0	1	100.0	0.4	1.6
					Laboratories	1 in 20 miles	0	1	100.0	2.0	2.3
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	0.4	0.4
		Hialeah	33012	4	Adult Primary Ca…	2 in 10 miles	130	4	100.0	0.2	0.3
					Pediatricians	2 in 10 miles	26	4	100.0	0.3	0.4
					OB/Gyns	2 in 15 miles	1	4	100.0	1.1	1.4
					Other Specialists	2 in 15 miles	342	4	100.0	0.2	0.2
					Hospitals	1 in 20 miles	1	4	100.0	0.6	1.8
					Laboratories	1 in 20 miles	2	4	100.0	0.7	1.3
					Urgent Care Facil…	1 in 20 miles	4	4	100.0	0.7	0.7
			33013	4	Adult Primary Ca…	2 in 10 miles	59	4	100.0	0.4	0.4
					Pediatricians	2 in 10 miles	11	4	100.0	0.4	0.4
					OB/Gyns	2 in 15 miles	11	4	100.0	1.3	1.3
					Other Specialists	2 in 15 miles	91	4	100.0	0.4	0.4
					Hospitals	1 in 20 miles	1	4	100.0	1.3	2.4
					Laboratories	1 in 20 miles	1	4	100.0	1.3	1.9
					Urgent Care Facil…	1 in 20 miles	0	4	100.0	2.3	2.3
			33014	3	Adult Primary Ca…	2 in 10 miles	102	3	100.0	0.3	0.3
					Pediatricians	2 in 10 miles	29	3	100.0	0.6	0.7
					OB/Gyns	2 in 15 miles	10	3	100.0	0.6	0.6
					Other Specialists	2 in 15 miles	327	3	100.0	0.2	0.3
					Hospitals	1 in 20 miles	2	3	100.0	0.8	1.3
					Laboratories	1 in 20 miles	1	3	100.0	0.7	0.9

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access											
State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Miami-Dade	Hialeah	33014	3	Urgent Care Facil…	1 in 20 miles	4	3	100.0	1.3	1.4
			33015	2	Adult Primary Ca…	2 in 10 miles	35	2	100.0	0.5	0.5
					Pediatricians	2 in 10 miles	2	2	100.0	0.8	1.1
					OB/Gyns	2 in 15 miles	0	2	100.0	1.5	1.5
					Other Specialists	2 in 15 miles	124	2	100.0	0.5	0.5
					Hospitals	1 in 20 miles	0	2	100.0	1.8	2.0
					Laboratories	1 in 20 miles	1	2	100.0	1.8	3.3
					Urgent Care Facil…	1 in 20 miles	3	2	100.0	0.6	1.2
			33016	1	Adult Primary Ca…	2 in 10 miles	117	1	100.0	0.2	0.2
					Pediatricians	2 in 10 miles	15	1	100.0	0.5	0.5
					OB/Gyns	2 in 15 miles	26	1	100.0	0.5	0.5
					Other Specialists	2 in 15 miles	698	1	100.0	0.1	0.1
					Hospitals	1 in 20 miles	2	1	100.0	0.5	0.8
					Laboratories	1 in 20 miles	1	1	100.0	0.5	1.5
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	1.4	1.6
			33018	7	Adult Primary Ca…	2 in 10 miles	20	7	100.0	0.4	0.6
					Pediatricians	2 in 10 miles	1	7	100.0	0.8	1.6
					OB/Gyns	2 in 15 miles	0	7	100.0	1.5	1.6
					Other Specialists	2 in 15 miles	56	7	100.0	0.3	0.3
					Hospitals	1 in 20 miles	0	7	100.0	1.5	1.9
					Laboratories	1 in 20 miles	0	7	100.0	1.7	2.7
					Urgent Care Facil…	1 in 20 miles	0	7	100.0	1.9	2.1
		Homestead	33030	2	Adult Primary Ca…	2 in 10 miles	98	2	100.0	0.4	0.4
					Pediatricians	2 in 10 miles	20	2	100.0	0.4	0.4
					OB/Gyns	2 in 15 miles	21	2	100.0	0.4	0.4
					Other Specialists	2 in 15 miles	257	2	100.0	0.4	0.4
					Hospitals	1 in 20 miles	0	2	100.0	2.4	3.5
					Laboratories	1 in 20 miles	0	2	100.0	1.7	10.1
					Urgent Care Facil…	1 in 20 miles	1	2	100.0	1.3	2.1
			33031	1	Adult Primary Ca…	2 in 10 miles	0	1	100.0	3.0	3.0
					Pediatricians	2 in 10 miles	0	1	100.0	3.0	3.0
					OB/Gyns	2 in 15 miles	0	1	100.0	3.2	3.2
					Other Specialists	2 in 15 miles	3	1	100.0	1.3	1.8
					Hospitals	1 in 20 miles	0	1	100.0	4.2	4.8
					Laboratories	1 in 20 miles	0	1	100.0	4.9	8.3
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	4.1	4.2
			33032	16	Adult Primary Ca…	2 in 10 miles	42	16	100.0	0.8	1.0
					Pediatricians	2 in 10 miles	6	16	100.0	1.1	1.1
					OB/Gyns	2 in 15 miles	10	16	100.0	1.2	1.2
					Other Specialists	2 in 15 miles	62	16	100.0	0.5	0.6

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access												
State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Miami-Dade	Homestead	33032	16	Hospitals	1 in 20 miles	0	16	100.0	3.5	4.1
					Laboratories	1 in 20 miles	0	16	100.0	4.2	5.0
					Urgent Care Facil…	1 in 20 miles	0	16	100.0	3.7	3.7
			33033	11	Adult Primary Ca…	2 in 10 miles	67	11	100.0	0.6	0.7
					Pediatricians	2 in 10 miles	23	11	100.0	0.8	0.8
					OB/Gyns	2 in 15 miles	23	11	100.0	1.0	1.0
					Other Specialists	2 in 15 miles	266	11	100.0	0.3	0.4
					Hospitals	1 in 20 miles	2	11	100.0	1.1	1.6
					Laboratories	1 in 20 miles	0	11	100.0	3.3	7.7
					Urgent Care Facil…	1 in 20 miles	4	11	100.0	1.4	1.5
			33034	3	Adult Primary Ca…	2 in 10 miles	34	3	100.0	0.8	1.0
					Pediatricians	2 in 10 miles	5	3	100.0	0.7	1.2
					OB/Gyns	2 in 15 miles	11	3	100.0	1.2	1.3
					Other Specialists	2 in 15 miles	46	3	100.0	0.3	0.3
					Hospitals	1 in 20 miles	0	3	100.0	4.5	5.4
					Laboratories	1 in 20 miles	1	3	100.0	2.4	13.0
					Urgent Care Facil…	1 in 20 miles	0	3	100.0	2.6	4.4
			33035	5	Adult Primary Ca…	2 in 10 miles	0	5	100.0	1.0	1.0
					Pediatricians	2 in 10 miles	0	5	100.0	1.7	1.9
					OB/Gyns	2 in 15 miles	0	5	100.0	2.0	2.1
					Other Specialists	2 in 15 miles	7	5	100.0	0.5	0.7
					Hospitals	1 in 20 miles	0	5	100.0	1.8	2.3
					Laboratories	1 in 20 miles	0	5	100.0	1.8	10.0
					Urgent Care Facil…	1 in 20 miles	0	5	100.0	1.7	1.8
		Miami	33122	1	Adult Primary Ca…	2 in 10 miles	22	1	100.0	0.4	0.4
					Pediatricians	2 in 10 miles	9	1	100.0	0.4	0.4
					OB/Gyns	2 in 15 miles	10	1	100.0	0.4	0.4
					Other Specialists	2 in 15 miles	235	1	100.0	0.2	0.2
					Hospitals	1 in 20 miles	1	1	100.0	0.4	2.0
					Laboratories	1 in 20 miles	0	1	100.0	1.2	2.2
					Urgent Care Facil…	1 in 20 miles	1	1	100.0	0.4	1.1
			33125	6	Adult Primary Ca…	2 in 10 miles	145	6	100.0	0.1	0.2
					Pediatricians	2 in 10 miles	2	6	100.0	0.3	0.5
					OB/Gyns	2 in 15 miles	23	6	100.0	0.7	0.8
					Other Specialists	2 in 15 miles	623	6	100.0	0.1	0.1
					Hospitals	1 in 20 miles	0	6	100.0	0.9	1.0
					Laboratories	1 in 20 miles	0	6	100.0	1.0	1.1
					Urgent Care Facil…	1 in 20 miles	0	6	100.0	1.8	2.1
			33126	11	Adult Primary Ca…	2 in 10 miles	99	11	100.0	0.2	0.3
					Pediatricians	2 in 10 miles	12	11	100.0	0.3	0.4

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access												
State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Miami-Dade	Miami	33126	11	OB/Gyns	2 in 15 miles	16	11	100.0	0.6	0.6
					Other Specialists	2 in 15 miles	606	11	100.0	0.1	0.2
					Hospitals	1 in 20 miles	1	11	100.0	1.2	1.7
					Laboratories	1 in 20 miles	0	11	100.0	1.7	2.3
					Urgent Care Facil...	1 in 20 miles	2	11	100.0	0.7	1.3
			33127	1	Adult Primary Ca...	2 in 10 miles	9	1	100.0	0.5	0.5
					Pediatricians	2 in 10 miles	3	1	100.0	0.5	0.5
					OB/Gyns	2 in 15 miles	0	1	100.0	0.5	0.6
					Other Specialists	2 in 15 miles	45	1	100.0	0.2	0.2
					Hospitals	1 in 20 miles	0	1	100.0	0.8	1.4
					Laboratories	1 in 20 miles	0	1	100.0	1.7	1.7
					Urgent Care Facil...	1 in 20 miles	0	1	100.0	0.8	0.8
			33128	1	Adult Primary Ca...	2 in 10 miles	6	1	100.0	0.1	0.1
					Pediatricians	2 in 10 miles	0	1	100.0	0.6	0.6
					OB/Gyns	2 in 15 miles	2	1	100.0	0.1	0.4
					Other Specialists	2 in 15 miles	7	1	100.0	0.1	0.1
					Hospitals	1 in 20 miles	1	1	100.0	0.3	1.0
					Laboratories	1 in 20 miles	0	1	100.0	0.9	1.1
					Urgent Care Facil...	1 in 20 miles	0	1	100.0	1.2	1.8
			33129	2	Adult Primary Ca...	2 in 10 miles	3	2	100.0	0.4	0.6
					Pediatricians	2 in 10 miles	7	2	100.0	0.2	0.3
					OB/Gyns	2 in 15 miles	1	2	100.0	0.6	0.8
					Other Specialists	2 in 15 miles	31	2	100.0	0.0	0.0
					Hospitals	1 in 20 miles	1	2	100.0	0.6	1.3
					Laboratories	1 in 20 miles	0	2	100.0	2.1	2.2
					Urgent Care Facil...	1 in 20 miles	1	2	100.0	0.6	0.7
			33130	1	Adult Primary Ca...	2 in 10 miles	32	1	100.0	0.1	0.3
					Pediatricians	2 in 10 miles	6	1	100.0	0.3	0.5
					OB/Gyns	2 in 15 miles	2	1	100.0	0.4	0.4
					Other Specialists	2 in 15 miles	114	1	100.0	0.1	0.2
					Hospitals	1 in 20 miles	0	1	100.0	0.8	1.3
					Laboratories	1 in 20 miles	0	1	100.0	1.5	1.6
					Urgent Care Facil...	1 in 20 miles	1	1	100.0	0.7	1.3
			33132	2	Adult Primary Ca...	2 in 10 miles	6	2	100.0	0.2	0.6
					Pediatricians	2 in 10 miles	0	2	100.0	0.8	1.2
					OB/Gyns	2 in 15 miles	0	2	100.0	0.7	0.7
					Other Specialists	2 in 15 miles	44	2	100.0	0.2	0.2
					Hospitals	1 in 20 miles	0	2	100.0	1.3	1.3
					Laboratories	1 in 20 miles	0	2	100.0	1.4	1.5
					Urgent Care Facil...	1 in 20 miles	0	2	100.0	1.2	1.5

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access												
State Name	County	City	Zip Code	Employee #	Provider Group	Provider Standard	Counts #	With Access #	With Access %	Average Distance 1	Average Distance 2
Florida	Miami-Dade	Miami	33133	16	Adult Primary Ca…	2 in 10 miles	158	16	100.0	0.3	0.4
					Pediatricians	2 in 10 miles	18	16	100.0	0.5	0.5
					OB/Gyns	2 in 15 miles	71	16	100.0	0.5	0.6
					Other Specialists	2 in 15 miles	579	16	100.0	0.3	0.3
					Hospitals	1 in 20 miles	1	16	100.0	1.2	1.5
					Laboratories	1 in 20 miles	0	16	100.0	2.8	3.1
					Urgent Care Facil…	1 in 20 miles	0	16	100.0	1.2	1.6
			33134	37	Adult Primary Ca…	2 in 10 miles	160	37	100.0	0.3	0.3
					Pediatricians	2 in 10 miles	12	37	100.0	0.4	0.6
					OB/Gyns	2 in 15 miles	6	37	100.0	0.7	0.8
					Other Specialists	2 in 15 miles	1,126	37	100.0	0.2	0.2
					Hospitals	1 in 20 miles	2	37	100.0	0.8	1.4
					Laboratories	1 in 20 miles	0	37	100.0	2.0	2.2
					Urgent Care Facil…	1 in 20 miles	4	37	100.0	0.6	0.9
			33135	7	Adult Primary Ca…	2 in 10 miles	64	7	100.0	0.2	0.2
					Pediatricians	2 in 10 miles	2	7	100.0	0.4	0.5
					OB/Gyns	2 in 15 miles	0	7	100.0	1.1	1.2
					Other Specialists	2 in 15 miles	130	7	100.0	0.1	0.1
					Hospitals	1 in 20 miles	0	7	100.0	1.3	1.6
					Laboratories	1 in 20 miles	0	7	100.0	1.8	1.8
					Urgent Care Facil…	1 in 20 miles	0	7	100.0	1.2	1.3
			33136	1	Adult Primary Ca…	2 in 10 miles	871	1	100.0	0.1	0.1
					Pediatricians	2 in 10 miles	248	1	100.0	0.2	0.4
					OB/Gyns	2 in 15 miles	126	1	100.0	0.1	0.5
					Other Specialists	2 in 15 miles	5,264	1	100.0	0.1	0.1
					Hospitals	1 in 20 miles	5	1	100.0	0.6	0.6
					Laboratories	1 in 20 miles	2	1	100.0	0.5	0.7
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	1.4	1.7
			33137	2	Adult Primary Ca…	2 in 10 miles	99	2	100.0	0.1	0.1
					Pediatricians	2 in 10 miles	17	2	100.0	0.1	0.2
					OB/Gyns	2 in 15 miles	14	2	100.0	0.2	0.3
					Other Specialists	2 in 15 miles	287	2	100.0	0.1	0.1
					Hospitals	1 in 20 miles	1	2	100.0	0.5	1.7
					Laboratories	1 in 20 miles	0	2	100.0	1.9	2.0
					Urgent Care Facil…	1 in 20 miles	4	2	100.0	0.1	0.5
			33138	1	Adult Primary Ca…	2 in 10 miles	43	1	100.0	0.2	0.2
					Pediatricians	2 in 10 miles	5	1	100.0	0.5	0.5
					OB/Gyns	2 in 15 miles	2	1	100.0	0.5	0.5
					Other Specialists	2 in 15 miles	82	1	100.0	0.1	0.2
					Hospitals	1 in 20 miles	0	1	100.0	2.6	3.9

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access												
State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Miami-Dade	Miami	33138	1	Laboratories	1 in 20 miles	0	1	100.0	2.0	3.5
					Urgent Care Facil…	1 in 20 miles	1	1	100.0	1.0	2.6
			33142	9	Adult Primary Ca…	2 in 10 miles	60	9	100.0	0.3	0.4
					Pediatricians	2 in 10 miles	14	9	100.0	0.6	0.6
					OB/Gyns	2 in 15 miles	2	9	100.0	0.9	0.9
					Other Specialists	2 in 15 miles	59	9	100.0	0.3	0.4
					Hospitals	1 in 20 miles	0	9	100.0	2.0	2.2
					Laboratories	1 in 20 miles	1	9	100.0	1.4	1.9
					Urgent Care Facil…	1 in 20 miles	0	9	100.0	2.7	2.7
			33143	15	Adult Primary Ca…	2 in 10 miles	179	15	100.0	0.3	0.4
					Pediatricians	2 in 10 miles	19	15	100.0	0.4	0.5
					OB/Gyns	2 in 15 miles	87	15	100.0	0.5	0.5
					Other Specialists	2 in 15 miles	1,209	15	100.0	0.2	0.3
					Hospitals	1 in 20 miles	3	15	100.0	0.9	1.2
					Laboratories	1 in 20 miles	2	15	100.0	0.8	0.9
					Urgent Care Facil…	1 in 20 miles	1	15	100.0	1.0	1.5
			33144	6	Adult Primary Ca…	2 in 10 miles	130	6	100.0	0.3	0.3
					Pediatricians	2 in 10 miles	10	6	100.0	0.3	0.7
					OB/Gyns	2 in 15 miles	1	6	100.0	1.0	1.1
					Other Specialists	2 in 15 miles	198	6	100.0	0.2	0.2
					Hospitals	1 in 20 miles	0	6	100.0	1.2	1.3
					Laboratories	1 in 20 miles	1	6	100.0	1.2	1.9
					Urgent Care Facil…	1 in 20 miles	0	6	100.0	1.5	1.7
			33145	9	Adult Primary Ca…	2 in 10 miles	32	9	100.0	0.2	0.3
					Pediatricians	2 in 10 miles	3	9	100.0	0.5	0.5
					OB/Gyns	2 in 15 miles	0	9	100.0	1.0	1.0
					Other Specialists	2 in 15 miles	191	9	100.0	0.2	0.2
					Hospitals	1 in 20 miles	0	9	100.0	1.0	1.4
					Laboratories	1 in 20 miles	0	9	100.0	2.6	2.6
					Urgent Care Facil…	1 in 20 miles	2	9	100.0	0.4	0.7
			33146	12	Adult Primary Ca…	2 in 10 miles	241	12	100.0	0.3	0.4
					Pediatricians	2 in 10 miles	48	12	100.0	0.5	0.5
					OB/Gyns	2 in 15 miles	49	12	100.0	0.5	0.7
					Other Specialists	2 in 15 miles	1,115	12	100.0	0.3	0.3
					Hospitals	1 in 20 miles	4	12	100.0	0.6	0.7
					Laboratories	1 in 20 miles	0	12	100.0	1.2	1.6
					Urgent Care Facil…	1 in 20 miles	1	12	100.0	0.9	1.8
			33147	13	Adult Primary Ca…	2 in 10 miles	42	13	100.0	0.4	0.5
					Pediatricians	2 in 10 miles	5	13	100.0	0.5	0.6
					OB/Gyns	2 in 15 miles	0	13	100.0	1.0	1.1

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access												
State Name	County	City	Zip Code	Employee #	Provider Group	Provider Standard	Counts #	With Access #	With Access %	Average Distance 1	Average Distance 2
Florida	Miami-Dade	Miami	33147	13	Other Specialists	2 in 15 miles	160	13	100.0	0.3	0.3
					Hospitals	1 in 20 miles	0	13	100.0	2.1	3.4
					Laboratories	1 in 20 miles	1	13	100.0	0.9	2.0
					Urgent Care Facil…	1 in 20 miles	0	13	100.0	2.9	3.4
			33150	2	Adult Primary Ca…	2 in 10 miles	52	2	100.0	0.7	0.7
					Pediatricians	2 in 10 miles	9	2	100.0	0.7	0.7
					OB/Gyns	2 in 15 miles	9	2	100.0	0.7	0.7
					Other Specialists	2 in 15 miles	127	2	100.0	0.4	0.6
					Hospitals	1 in 20 miles	0	2	100.0	2.4	3.7
					Laboratories	1 in 20 miles	0	2	100.0	2.4	3.1
					Urgent Care Facil…	1 in 20 miles	0	2	100.0	1.5	2.4
			33155	36	Adult Primary Ca…	2 in 10 miles	419	36	100.0	0.3	0.3
					Pediatricians	2 in 10 miles	114	36	100.0	0.6	0.6
					OB/Gyns	2 in 15 miles	2	36	100.0	1.0	1.1
					Other Specialists	2 in 15 miles	1,112	36	100.0	0.2	0.2
					Hospitals	1 in 20 miles	3	36	100.0	0.9	1.1
					Laboratories	1 in 20 miles	2	36	100.0	1.0	1.4
					Urgent Care Facil…	1 in 20 miles	2	36	100.0	0.8	1.3
			33156	9	Adult Primary Ca…	2 in 10 miles	76	9	100.0	0.9	0.9
					Pediatricians	2 in 10 miles	17	9	100.0	1.2	1.2
					OB/Gyns	2 in 15 miles	24	9	100.0	1.6	1.7
					Other Specialists	2 in 15 miles	559	9	100.0	0.3	0.5
					Hospitals	1 in 20 miles	1	9	100.0	1.5	2.0
					Laboratories	1 in 20 miles	2	9	100.0	1.8	2.0
					Urgent Care Facil…	1 in 20 miles	4	9	100.0	1.1	1.5
			33157	21	Adult Primary Ca…	2 in 10 miles	104	21	100.0	0.6	0.7
					Pediatricians	2 in 10 miles	31	21	100.0	0.8	0.9
					OB/Gyns	2 in 15 miles	23	21	100.0	1.1	1.1
					Other Specialists	2 in 15 miles	523	21	100.0	0.3	0.5
					Hospitals	1 in 20 miles	2	21	100.0	1.3	2.2
					Laboratories	1 in 20 miles	1	21	100.0	1.7	2.2
					Urgent Care Facil…	1 in 20 miles	5	21	100.0	1.0	1.0
			33158	3	Adult Primary Ca…	2 in 10 miles	1	3	100.0	0.6	0.8
					Pediatricians	2 in 10 miles	0	3	100.0	1.0	1.0
					OB/Gyns	2 in 15 miles	0	3	100.0	1.5	1.5
					Other Specialists	2 in 15 miles	1	3	100.0	0.7	0.8
					Hospitals	1 in 20 miles	0	3	100.0	1.6	1.9
					Laboratories	1 in 20 miles	0	3	100.0	3.2	3.5
					Urgent Care Facil…	1 in 20 miles	0	3	100.0	0.9	1.0
			33161	4	Adult Primary Ca…	2 in 10 miles	89	4	100.0	0.2	0.3

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access												
State Name	County	City	Zip Code	Employee #	Provider Group	Provider Standard	Counts #	With Access #	With Access %	Average Distance 1	Average Distance 2
Florida	Miami-Dade	Miami	33161	4	Pediatricians	2 in 10 miles	17	4	100.0	0.5	0.5
					OB/Gyns	2 in 15 miles	8	4	100.0	0.4	0.4
					Other Specialists	2 in 15 miles	221	4	100.0	0.2	0.2
					Hospitals	1 in 20 miles	0	4	100.0	3.2	5.2
					Laboratories	1 in 20 miles	1	4	100.0	1.2	2.8
					Urgent Care Facil…	1 in 20 miles	0	4	100.0	1.4	1.5
			33162	1	Adult Primary Ca…	2 in 10 miles	56	1	100.0	0.1	0.1
					Pediatricians	2 in 10 miles	11	1	100.0	0.2	0.2
					OB/Gyns	2 in 15 miles	9	1	100.0	0.6	0.9
					Other Specialists	2 in 15 miles	215	1	100.0	0.1	0.1
					Hospitals	1 in 20 miles	0	1	100.0	1.5	3.4
					Laboratories	1 in 20 miles	1	1	100.0	1.2	1.5
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	1.6	1.7
			33165	18	Adult Primary Ca…	2 in 10 miles	61	18	100.0	0.3	0.4
					Pediatricians	2 in 10 miles	16	18	100.0	0.5	0.5
					OB/Gyns	2 in 15 miles	1	18	100.0	1.0	1.3
					Other Specialists	2 in 15 miles	132	18	100.0	0.3	0.3
					Hospitals	1 in 20 miles	0	18	100.0	1.7	2.6
					Laboratories	1 in 20 miles	2	18	100.0	1.2	2.1
					Urgent Care Facil…	1 in 20 miles	3	18	100.0	1.0	1.5
			33166	4	Adult Primary Ca…	2 in 10 miles	40	4	100.0	0.6	0.6
					Pediatricians	2 in 10 miles	10	4	100.0	0.7	0.7
					OB/Gyns	2 in 15 miles	26	4	100.0	0.8	1.0
					Other Specialists	2 in 15 miles	423	4	100.0	0.4	0.4
					Hospitals	1 in 20 miles	0	4	100.0	1.8	2.4
					Laboratories	1 in 20 miles	0	4	100.0	1.6	2.4
					Urgent Care Facil…	1 in 20 miles	0	4	100.0	2.1	2.4
			33167	2	Adult Primary Ca…	2 in 10 miles	18	2	100.0	1.0	1.0
					Pediatricians	2 in 10 miles	3	2	100.0	1.0	1.0
					OB/Gyns	2 in 15 miles	0	2	100.0	2.2	2.2
					Other Specialists	2 in 15 miles	14	2	100.0	0.4	0.4
					Hospitals	1 in 20 miles	0	2	100.0	3.3	3.9
					Laboratories	1 in 20 miles	0	2	100.0	2.2	2.9
					Urgent Care Facil…	1 in 20 miles	0	2	100.0	2.5	3.1
			33168	5	Adult Primary Ca…	2 in 10 miles	10	5	100.0	0.4	0.4
					Pediatricians	2 in 10 miles	0	5	100.0	1.0	1.0
					OB/Gyns	2 in 15 miles	0	5	100.0	1.5	1.5
					Other Specialists	2 in 15 miles	9	5	100.0	0.3	0.4
					Hospitals	1 in 20 miles	0	5	100.0	2.7	4.8
					Laboratories	1 in 20 miles	0	5	100.0	2.4	2.4

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access											
State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Miami-Dade	Miami	33168	5	Urgent Care Facil…	1 in 20 miles	0	5	100.0	2.1	2.9
			33169	2	Adult Primary Ca…	2 in 10 miles	105	2	100.0	0.4	0.5
					Pediatricians	2 in 10 miles	41	2	100.0	0.5	0.7
					OB/Gyns	2 in 15 miles	16	2	100.0	0.6	1.2
					Other Specialists	2 in 15 miles	350	2	100.0	0.1	0.1
					Hospitals	1 in 20 miles	1	2	100.0	1.7	3.9
					Laboratories	1 in 20 miles	4	2	100.0	0.5	1.2
					Urgent Care Facil…	1 in 20 miles	1	2	100.0	1.4	2.7
			33170	6	Adult Primary Ca…	2 in 10 miles	1	6	100.0	1.1	1.6
					Pediatricians	2 in 10 miles	0	6	100.0	1.8	2.1
					OB/Gyns	2 in 15 miles	0	6	100.0	2.3	2.3
					Other Specialists	2 in 15 miles	42	6	100.0	0.3	0.3
					Hospitals	1 in 20 miles	0	6	100.0	4.5	5.5
					Laboratories	1 in 20 miles	0	6	100.0	3.0	3.7
					Urgent Care Facil…	1 in 20 miles	0	6	100.0	3.5	3.6
			33172	5	Adult Primary Ca…	2 in 10 miles	26	5	100.0	0.2	0.4
					Pediatricians	2 in 10 miles	12	5	100.0	0.7	0.9
					OB/Gyns	2 in 15 miles	0	5	100.0	1.1	1.2
					Other Specialists	2 in 15 miles	278	5	100.0	0.2	0.2
					Hospitals	1 in 20 miles	0	5	100.0	1.4	1.7
					Laboratories	1 in 20 miles	1	5	100.0	1.5	2.4
					Urgent Care Facil…	1 in 20 miles	2	5	100.0	0.6	1.0
			33173	10	Adult Primary Ca…	2 in 10 miles	100	10	100.0	0.3	0.3
					Pediatricians	2 in 10 miles	44	10	100.0	0.3	0.4
					OB/Gyns	2 in 15 miles	30	10	100.0	0.6	0.7
					Other Specialists	2 in 15 miles	899	10	100.0	0.2	0.2
					Hospitals	1 in 20 miles	0	10	100.0	1.5	2.6
					Laboratories	1 in 20 miles	0	10	100.0	1.2	1.8
					Urgent Care Facil…	1 in 20 miles	0	10	100.0	1.4	2.0
			33174	10	Adult Primary Ca…	2 in 10 miles	57	10	100.0	0.2	0.3
					Pediatricians	2 in 10 miles	8	10	100.0	0.4	0.6
					OB/Gyns	2 in 15 miles	6	10	100.0	0.6	0.7
					Other Specialists	2 in 15 miles	110	10	100.0	0.2	0.2
					Hospitals	1 in 20 miles	0	10	100.0	2.5	2.7
					Laboratories	1 in 20 miles	0	10	100.0	1.8	2.5
					Urgent Care Facil…	1 in 20 miles	1	10	100.0	0.8	2.0
			33175	9	Adult Primary Ca…	2 in 10 miles	132	9	100.0	0.3	0.4
					Pediatricians	2 in 10 miles	40	9	100.0	0.5	0.6
					OB/Gyns	2 in 15 miles	26	9	100.0	1.8	1.8
					Other Specialists	2 in 15 miles	513	9	100.0	0.2	0.3

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access												
State Name	County	City	Zip Code	Employee #	Provider Group	Provider Standard	Counts #	With Access #	With Access %	Average Distance 1	Average Distance 2
Florida	Miami-Dade	Miami	33175	9	Hospitals	1 in 20 miles	1	9	100.0	1.7	2.6
					Laboratories	1 in 20 miles	0	9	100.0	1.7	2.4
					Urgent Care Facil…	1 in 20 miles	2	9	100.0	1.1	1.6
			33176	15	Adult Primary Ca…	2 in 10 miles	308	15	100.0	0.8	1.0
					Pediatricians	2 in 10 miles	58	15	100.0	1.1	1.2
					OB/Gyns	2 in 15 miles	111	15	100.0	1.1	1.4
					Other Specialists	2 in 15 miles	2,602	15	100.0	0.3	0.5
					Hospitals	1 in 20 miles	1	15	100.0	1.8	2.2
					Laboratories	1 in 20 miles	1	15	100.0	1.9	2.2
					Urgent Care Facil…	1 in 20 miles	3	15	100.0	1.7	1.8
			33177	19	Adult Primary Ca…	2 in 10 miles	10	19	100.0	1.1	1.1
					Pediatricians	2 in 10 miles	1	19	100.0	1.5	2.1
					OB/Gyns	2 in 15 miles	0	19	100.0	2.4	2.4
					Other Specialists	2 in 15 miles	97	19	100.0	0.5	0.6
					Hospitals	1 in 20 miles	0	19	100.0	3.3	4.4
					Laboratories	1 in 20 miles	0	19	100.0	2.4	2.7
					Urgent Care Facil…	1 in 20 miles	2	19	100.0	2.0	2.1
			33178	3	Adult Primary Ca…	2 in 10 miles	50	3	100.0	0.4	0.6
					Pediatricians	2 in 10 miles	29	3	100.0	0.4	0.4
					OB/Gyns	2 in 15 miles	24	3	100.0	0.5	0.8
					Other Specialists	2 in 15 miles	255	3	100.0	0.4	0.4
					Hospitals	1 in 20 miles	2	3	100.0	1.6	1.9
					Laboratories	1 in 20 miles	0	3	100.0	3.1	3.8
					Urgent Care Facil…	1 in 20 miles	5	3	100.0	0.6	1.6
			33179	3	Adult Primary Ca…	2 in 10 miles	40	3	100.0	0.3	0.3
					Pediatricians	2 in 10 miles	15	3	100.0	0.9	1.0
					OB/Gyns	2 in 15 miles	3	3	100.0	0.8	1.0
					Other Specialists	2 in 15 miles	164	3	100.0	0.1	0.2
					Hospitals	1 in 20 miles	0	3	100.0	2.1	2.4
					Laboratories	1 in 20 miles	0	3	100.0	1.4	1.9
					Urgent Care Facil…	1 in 20 miles	1	3	100.0	1.0	1.8
			33182	5	Adult Primary Ca…	2 in 10 miles	0	5	100.0	1.3	1.4
					Pediatricians	2 in 10 miles	0	5	100.0	1.3	2.0
					OB/Gyns	2 in 15 miles	0	5	100.0	2.4	2.8
					Other Specialists	2 in 15 miles	15	5	100.0	0.2	0.4
					Hospitals	1 in 20 miles	0	5	100.0	2.1	2.9
					Laboratories	1 in 20 miles	0	5	100.0	1.7	3.6
					Urgent Care Facil…	1 in 20 miles	0	5	100.0	2.1	2.1
			33183	5	Adult Primary Ca…	2 in 10 miles	38	5	100.0	0.6	0.7
					Pediatricians	2 in 10 miles	7	5	100.0	0.6	0.7

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access												
State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Miami-Dade	Miami	33183	5	OB/Gyns	2 in 15 miles	18	5	100.0	1.8	1.8
					Other Specialists	2 in 15 miles	188	5	100.0	0.3	0.3
					Hospitals	1 in 20 miles	0	5	100.0	2.3	3.5
					Laboratories	1 in 20 miles	1	5	100.0	1.8	2.2
					Urgent Care Facil…	1 in 20 miles	0	5	100.0	1.2	1.6
			33184	2	Adult Primary Ca…	2 in 10 miles	26	2	100.0	0.4	0.5
					Pediatricians	2 in 10 miles	2	2	100.0	0.5	1.4
					OB/Gyns	2 in 15 miles	0	2	100.0	2.3	2.4
					Other Specialists	2 in 15 miles	44	2	100.0	0.2	0.2
					Hospitals	1 in 20 miles	1	2	100.0	1.3	2.4
					Laboratories	1 in 20 miles	1	2	100.0	0.7	2.6
					Urgent Care Facil…	1 in 20 miles	2	2	100.0	1.3	1.3
			33185	1	Adult Primary Ca…	2 in 10 miles	12	1	100.0	1.0	1.1
					Pediatricians	2 in 10 miles	3	1	100.0	1.0	1.5
					OB/Gyns	2 in 15 miles	0	1	100.0	3.6	3.7
					Other Specialists	2 in 15 miles	26	1	100.0	0.2	0.2
					Hospitals	1 in 20 miles	0	1	100.0	2.2	3.8
					Laboratories	1 in 20 miles	0	1	100.0	2.6	3.3
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	1.5	2.2
			33186	24	Adult Primary Ca…	2 in 10 miles	122	24	100.0	0.4	0.4
					Pediatricians	2 in 10 miles	23	24	100.0	0.6	0.8
					OB/Gyns	2 in 15 miles	18	24	100.0	1.0	1.1
					Other Specialists	2 in 15 miles	698	24	100.0	0.3	0.3
					Hospitals	1 in 20 miles	1	24	100.0	1.3	3.3
					Laboratories	1 in 20 miles	3	24	100.0	1.2	1.3
					Urgent Care Facil…	1 in 20 miles	7	24	100.0	0.9	1.0
			33187	10	Adult Primary Ca…	2 in 10 miles	3	10	100.0	1.7	3.3
					Pediatricians	2 in 10 miles	0	10	100.0	4.6	5.2
					OB/Gyns	2 in 15 miles	0	10	100.0	5.3	5.3
					Other Specialists	2 in 15 miles	15	10	100.0	1.1	1.1
					Hospitals	1 in 20 miles	0	10	100.0	5.9	6.5
					Laboratories	1 in 20 miles	0	10	100.0	6.4	6.8
					Urgent Care Facil…	1 in 20 miles	0	10	100.0	4.9	5.0
			33189	8	Adult Primary Ca…	2 in 10 miles	15	8	100.0	0.5	0.5
					Pediatricians	2 in 10 miles	2	8	100.0	1.3	1.4
					OB/Gyns	2 in 15 miles	0	8	100.0	1.4	1.4
					Other Specialists	2 in 15 miles	121	8	100.0	0.3	0.4
					Hospitals	1 in 20 miles	0	8	100.0	2.6	4.1
					Laboratories	1 in 20 miles	1	8	100.0	1.7	2.0
					Urgent Care Facil…	1 in 20 miles	0	8	100.0	1.9	2.0

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access												
State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Miami-Dade	Miami	33190	2	Adult Primary Ca…	2 in 10 miles	42	2	100.0	0.7	0.7
					Pediatricians	2 in 10 miles	7	2	100.0	0.8	0.8
					OB/Gyns	2 in 15 miles	16	2	100.0	0.8	0.8
					Other Specialists	2 in 15 miles	46	2	100.0	0.2	0.3
					Hospitals	1 in 20 miles	0	2	100.0	3.1	4.7
					Laboratories	1 in 20 miles	0	2	100.0	1.6	2.1
					Urgent Care Facil…	1 in 20 miles	0	2	100.0	2.2	2.2
			33193	17	Adult Primary Ca…	2 in 10 miles	8	17	100.0	0.5	0.5
					Pediatricians	2 in 10 miles	1	17	100.0	0.7	1.0
					OB/Gyns	2 in 15 miles	0	17	100.0	1.6	1.6
					Other Specialists	2 in 15 miles	84	17	100.0	0.3	0.4
					Hospitals	1 in 20 miles	0	17	100.0	1.7	3.5
					Laboratories	1 in 20 miles	0	17	100.0	1.2	3.5
					Urgent Care Facil…	1 in 20 miles	0	17	100.0	1.4	1.9
			33194	2	Adult Primary Ca…	2 in 10 miles	2	2	100.0	0.2	0.2
					Pediatricians	2 in 10 miles	0	2	100.0	0.9	1.1
					OB/Gyns	2 in 15 miles	0	2	100.0	4.0	4.0
					Other Specialists	2 in 15 miles	0	2	100.0	0.5	0.6
					Hospitals	1 in 20 miles	0	2	100.0	1.0	4.1
					Laboratories	1 in 20 miles	0	2	100.0	1.7	4.3
					Urgent Care Facil…	1 in 20 miles	0	2	100.0	1.0	1.0
			33196	5	Adult Primary Ca…	2 in 10 miles	57	5	100.0	0.6	0.6
					Pediatricians	2 in 10 miles	2	5	100.0	0.9	1.4
					OB/Gyns	2 in 15 miles	12	5	100.0	0.9	0.9
					Other Specialists	2 in 15 miles	245	5	100.0	0.4	0.4
					Hospitals	1 in 20 miles	1	5	100.0	1.3	2.5
					Laboratories	1 in 20 miles	1	5	100.0	1.8	3.1
					Urgent Care Facil…	1 in 20 miles	0	5	100.0	2.0	2.2
			33255	1	Adult Primary Ca…	2 in 10 miles	0	1	100.0	0.1	0.5
					Pediatricians	2 in 10 miles	0	1	100.0	0.9	0.9
					OB/Gyns	2 in 15 miles	0	1	100.0	0.9	0.9
					Other Specialists	2 in 15 miles	0	1	100.0	0.3	0.3
					Hospitals	1 in 20 miles	0	1	100.0	0.9	1.2
					Laboratories	1 in 20 miles	0	1	100.0	0.9	1.1
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	0.3	0.9
		Miami Beach	33139	1	Adult Primary Ca…	2 in 10 miles	74	1	100.0	0.3	0.3
					Pediatricians	2 in 10 miles	3	1	100.0	0.7	0.7
					OB/Gyns	2 in 15 miles	9	1	100.0	0.7	0.7
					Other Specialists	2 in 15 miles	207	1	100.0	0.1	0.1
					Hospitals	1 in 20 miles	0	1	100.0	2.0	3.8

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access

State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Miami-Dade	Miami Beach	33139	1	Laboratories	1 in 20 miles	0	1	100.0	2.0	4.7
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	1.9	3.4
			33141	1	Adult Primary Ca…	2 in 10 miles	35	1	100.0	0.1	0.1
					Pediatricians	2 in 10 miles	4	1	100.0	0.1	0.1
					OB/Gyns	2 in 15 miles	8	1	100.0	0.1	0.1
					Other Specialists	2 in 15 miles	45	1	100.0	0.1	0.1
					Hospitals	1 in 20 miles	0	1	100.0	2.9	4.7
					Laboratories	1 in 20 miles	0	1	100.0	2.8	2.9
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	2.9	3.1
			33154	1	Adult Primary Ca…	2 in 10 miles	8	1	100.0	0.1	0.2
					Pediatricians	2 in 10 miles	9	1	100.0	0.2	0.2
					OB/Gyns	2 in 15 miles	1	1	100.0	0.2	2.1
					Other Specialists	2 in 15 miles	53	1	100.0	0.2	0.2
					Hospitals	1 in 20 miles	0	1	100.0	4.8	5.5
					Laboratories	1 in 20 miles	0	1	100.0	2.6	3.4
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	2.2	2.2
		Miami Gard…	33056	1	Adult Primary Ca…	2 in 10 miles	23	1	100.0	0.4	0.4
					Pediatricians	2 in 10 miles	4	1	100.0	0.4	0.6
					OB/Gyns	2 in 15 miles	3	1	100.0	0.6	1.1
					Other Specialists	2 in 15 miles	68	1	100.0	0.4	0.6
					Hospitals	1 in 20 miles	0	1	100.0	3.1	4.0
					Laboratories	1 in 20 miles	0	1	100.0	1.9	2.2
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	1.5	2.8
		Opa Locka	33054	2	Adult Primary Ca…	2 in 10 miles	18	2	100.0	0.4	0.4
					Pediatricians	2 in 10 miles	2	2	100.0	0.5	1.3
					OB/Gyns	2 in 15 miles	2	2	100.0	1.3	1.3
					Other Specialists	2 in 15 miles	20	2	100.0	0.5	0.5
					Hospitals	1 in 20 miles	0	2	100.0	3.3	4.5
					Laboratories	1 in 20 miles	1	2	100.0	0.8	3.3
					Urgent Care Facil…	1 in 20 miles	1	2	100.0	1.3	3.4
			33055	3	Adult Primary Ca…	2 in 10 miles	23	3	100.0	0.5	0.5
					Pediatricians	2 in 10 miles	1	3	100.0	0.8	1.2
					OB/Gyns	2 in 15 miles	0	3	100.0	1.4	1.7
					Other Specialists	2 in 15 miles	33	3	100.0	0.5	0.6
					Hospitals	1 in 20 miles	0	3	100.0	2.7	3.5
					Laboratories	1 in 20 miles	0	3	100.0	2.6	3.2
					Urgent Care Facil…	1 in 20 miles	0	3	100.0	1.9	2.0
	Monroe	Key Largo	33037	1	Adult Primary Ca…	2 in 10 miles	15	1	100.0	0.8	2.7
					OB/Gyns	2 in 15 miles	1	1	100.0	0.8	12.3
					Other Specialists	2 in 15 miles	76	1	100.0	0.8	0.8

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access

State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Monroe	Key Largo	33037	1	Hospitals	1 in 20 miles	0	1	100.0	12.3	23.1
					Urgent Care Facil…	1 in 20 miles	1	1	100.0	3.7	22.5
		Marathon	33050	1	Adult Primary Ca…	2 in 10 miles	54	1	100.0	1.9	2.0
					Pediatricians	2 in 10 miles	6	1	100.0	0.3	3.7
					OB/Gyns	2 in 15 miles	14	1	100.0	3.7	3.7
					Other Specialists	2 in 15 miles	137	1	100.0	0.0	0.0
					Hospitals	1 in 20 miles	1	1	100.0	3.4	38.0
					Urgent Care Facil…	1 in 20 miles	1	1	100.0	1.7	46.3
	Palm Beach	Lake Worth…	33460	1	Adult Primary Ca…	2 in 10 miles	23	1	100.0	0.0	0.0
					Pediatricians	2 in 10 miles	5	1	100.0	0.5	0.5
					OB/Gyns	2 in 15 miles	0	1	100.0	1.8	1.8
					Other Specialists	2 in 15 miles	57	1	100.0	0.0	0.0
					Hospitals	1 in 20 miles	0	1	100.0	2.1	2.4
					Laboratories	1 in 20 miles	0	1	100.0	1.9	2.0
					Urgent Care Facil…	1 in 20 miles	1	1	100.0	0.1	1.7
		Pahokee	33476	1	Adult Primary Ca…	2 in 10 miles	11	1	100.0	0.2	0.4
					Pediatricians	2 in 10 miles	5	1	100.0	0.4	0.4
					OB/Gyns	2 in 15 miles	1	1	100.0	0.4	6.3
					Other Specialists	2 in 15 miles	11	1	100.0	0.2	0.4
					Hospitals	1 in 20 miles	0	1	100.0	6.3	17.8
					Laboratories	1 in 20 miles	0	1	100.0	9.0	9.2
	Polk	Kissimmee	34759	1	Adult Primary Ca…	2 in 10 miles	52	1	100.0	1.5	2.1
					Pediatricians	2 in 10 miles	0	1	100.0	2.9	2.9
					OB/Gyns	2 in 15 miles	2	1	100.0	2.1	2.1
					Other Specialists	2 in 15 miles	180	1	100.0	1.5	1.5
					Hospitals	1 in 20 miles	1	1	100.0	2.1	10.7
					Laboratories	1 in 20 miles	0	1	100.0	3.2	3.7
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	5.5	5.5
	St. Lucie	Port Saint L…	34953	2	Adult Primary Ca…	2 in 10 miles	14	2	100.0	0.9	0.9
					Pediatricians	2 in 10 miles	18	2	100.0	0.9	0.9
					OB/Gyns	2 in 15 miles	2	2	100.0	0.9	0.9
					Other Specialists	2 in 15 miles	141	2	100.0	0.4	0.6
					Hospitals	1 in 20 miles	1	2	100.0	1.2	3.0
					Laboratories	1 in 20 miles	2	2	100.0	1.4	2.0
					Urgent Care Facil…	1 in 20 miles	2	2	100.0	1.4	1.6
Georgia	Houston	Kathleen	31047	1	Adult Primary Ca…	2 in 10 miles	7	1	100.0	2.3	2.3
					Pediatricians	2 in 10 miles	5	1	100.0	2.9	2.9
					OB/Gyns	2 in 15 miles	1	1	100.0	3.0	4.9
					Other Specialists	2 in 15 miles	18	1	100.0	1.0	1.0
					Hospitals	1 in 20 miles	0	1	100.0	5.1	7.0

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access												
State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Georgia	Houston	Kathleen	31047	1	Laboratories	1 in 20 miles	0	1	100.0	7.1	23.8
					Urgent Care Facil…	1 in 20 miles	2	1	100.0	1.0	2.5
	Lowndes	Valdosta	31605	1	Adult Primary Ca…	2 in 10 miles	8	1	100.0	3.3	3.5
					Pediatricians	2 in 10 miles	0	1	100.0	4.3	4.3
					OB/Gyns	2 in 15 miles	1	1	100.0	4.6	4.7
					Other Specialists	2 in 15 miles	60	1	100.0	2.5	3.3
					Hospitals	1 in 20 miles	0	1	100.0	5.6	5.6
					Laboratories	1 in 20 miles	0	1	100.0	4.8	4.9
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	4.2	4.8
Oregon	Jackson	Medford	97504	1	Adult Primary Ca…	2 in 10 miles	432	1	100.0	0.7	0.7
					Pediatricians	2 in 10 miles	71	1	100.0	0.7	0.7
					OB/Gyns	2 in 15 miles	29	1	100.0	0.7	0.7
					Other Specialists	2 in 15 miles	2,180	1	100.0	0.2	0.2
					Hospitals	1 in 20 miles	2	1	100.0	0.7	1.5
					Laboratories	1 in 20 miles	1	1	100.0	0.9	3.9
South Carolina	Greenville	Travelers Rest	29690	1	Adult Primary Ca…	2 in 10 miles	194	1	100.0	3.0	3.0
					Pediatricians	2 in 10 miles	71	1	100.0	3.0	3.0
					OB/Gyns	2 in 15 miles	26	1	100.0	3.0	3.0
					Other Specialists	2 in 15 miles	521	1	100.0	3.0	3.0
					Hospitals	1 in 20 miles	1	1	100.0	3.0	12.2
					Laboratories	1 in 20 miles	0	1	100.0	12.1	12.3
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	9.1	10.2
Tennessee	Sumner	Gallatin	37066	1	Adult Primary Ca…	2 in 10 miles	363	1	100.0	0.3	0.3
					Pediatricians	2 in 10 miles	75	1	100.0	2.2	2.2
					OB/Gyns	2 in 15 miles	20	1	100.0	1.1	2.0
					Other Specialists	2 in 15 miles	936	1	100.0	0.3	0.3
					Hospitals	1 in 20 miles	2	1	100.0	1.8	2.2
					Laboratories	1 in 20 miles	0	1	100.0	13.4	14.5
					Urgent Care Facil…	1 in 20 miles	3	1	100.0	0.3	0.4
Washington	Pierce	Tacoma	98404	1	Adult Primary Ca…	2 in 10 miles	33	1	100.0	0.7	0.7
					Pediatricians	2 in 10 miles	4	1	100.0	0.7	0.7
					OB/Gyns	2 in 15 miles	1	1	100.0	0.7	2.4
					Other Specialists	2 in 15 miles	75	1	100.0	0.7	0.7
					Hospitals	1 in 20 miles	1	1	100.0	1.2	3.0
					Laboratories	1 in 20 miles	0	1	100.0	2.9	2.9
					Urgent Care Facil…	1 in 20 miles	0	1	100.0	4.1	4.1
Grand Totals				537	Adult Primary Ca…	2 in 10 miles	8,220	537	100.0	0.5	0.6
				536	Pediatricians	2 in 10 miles	1,948	536	100.0	0.8	1.0
				537	OB/Gyns	2 in 15 miles	1,434	537	100.0	1.2	1.3

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees With Access											
State Name	County	City	Zip Code	Employee #	Provider Group	Provider Standard	Counts #	With Access #	With Access %	Average Distance 1	Average Distance 2
Grand Totals				537	Other Specialists	2 in 15 miles	39,010	537	100.0	0.3	0.4
					Hospitals	1 in 20 miles	81	537	100.0	1.8	2.7
				535	Laboratories	1 in 20 miles	64	535	100.0	1.9	2.7
					Urgent Care Facil…	1 in 20 miles	121	535	100.0	1.5	2.0

Access Detail By Zip Code (Without Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Medical - Breakout - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Adult Primary Care Physicians
Pediatricians
OB/Gyns
Other Specialists
Hospitals
Laboratories
Urgent Care Facilities

Employees Without Access

State Name	County	City	Zip Code	Employee	Provider		Counts	Without Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Monroe	Key Largo	33037	1	Pediatricians	2 in 10 miles	1	1	100.0	4.8	12.3
					Laboratories	1 in 20 miles	0	1	100.0	22.1	29.9
		Marathon	33050	1	Laboratories	1 in 20 miles	0	1	100.0	47.2	61.7
	Palm Beach	Pahokee	33476	1	Urgent Care Faci…	1 in 20 miles	0	1	100.0	28.5	29.7
Oregon	Jackson	Medford	97504	1	Urgent Care Faci…	1 in 20 miles	0	1	100.0	67.4	118.2
Grand Totals				1	Pediatricians	2 in 10 miles	1	1	100.0	4.8	12.3
				2	Laboratories	1 in 20 miles	0	2	100.0	34.7	45.8
					Urgent Care Faci…	1 in 20 miles	0	2	100.0	48.0	74.0

Access Detail By Zip Code (Excluded from Analysis)

July 2024

Created for...
City of Coral Gables

Access Analysis
Invalid Zip Codes

Distance Method
Straight Line Distance

Employee / Facility Groups
All Employees
Hospitals

Employees Excluded from Analysis	
Zip Code	Employee #
No data that meets the criteria	

Cigna Network Analysis

Cigna 90 Now CVS

Created for...

City of Coral Gables

July 2024

Contents

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Access Summary By City (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Cigna 90 Now CVS - Standard - All

Distance Method
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Employee Group
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Provider Group
Cigna 90 Now CVS

Areas With Access
Top 36 Cities in the market, sorted by the number of employees with access

[1] Provider counts represent:
#: Provider access points

Employees With Access

Employee Group	537 employees 537 (100.0%) employees with access	Provider Group	62,591 unique providers at 60,955 unique locations (62,591 total access points)

Key Geographic Areas

	State Name	City	Employee	Provider		With Access		Counts[1]	Average Distance	
			#	Group	Standard	#	%	#	1	2
With Access	Florida	Miami	422	Cigna 90 Now CVS	1 in 5 miles	422	100.0	388	0.5	0.7
		Homestead	38	Cigna 90 Now CVS	1 in 5 miles	38	100.0	39	0.7	0.9
		Hialeah	21	Cigna 90 Now CVS	1 in 5 miles	21	100.0	99	0.5	0.6
		Hollywood	20	Cigna 90 Now CVS	1 in 5 miles	20	100.0	106	0.5	0.7
		Fort Lauderdale	6	Cigna 90 Now CVS	1 in 5 miles	6	100.0	203	0.7	0.9
		Opa Locka	5	Cigna 90 Now CVS	1 in 5 miles	5	100.0	9	0.5	0.7
		Miami Beach	3	Cigna 90 Now CVS	1 in 5 miles	3	100.0	33	0.2	0.3
		Palm Coast	3	Cigna 90 Now CVS	1 in 5 miles	3	100.0	18	1.8	2.1
		Port Saint Lucie	2	Cigna 90 Now CVS	1 in 5 miles	2	100.0	40	1.1	1.4
		Coral Gables	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	0	0.0	0.5
		Hallandale	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	15	0.1	0.3
		Key Largo	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	4	2.6	4.5
		Kissimmee	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	73	2.1	2.2
		Lake Worth Beach	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	6	0.1	0.1
		Marathon	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	4	0.3	2.2
		Miami Gardens	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	6	0.6	0.9
		Pahokee	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	1	0.4	9.0
		Pembroke Pines	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	2	0.5	0.7
		Pompano Beach	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	63	0.5	0.9
		Stuart	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	20	0.6	0.7
	Georgia	Kathleen	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	1	2.5	2.6
		Valdosta	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	23	1.4	3.9
	Oregon	Medford	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	22	0.7	0.8
	South Carolina	Travelers Rest	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	5	2.4	2.5
	Tennessee	Gallatin	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	15	0.3	0.4
	Washington	Tacoma	1	Cigna 90 Now CVS	1 in 5 miles	1	100.0	49	0.7	0.9

Access Summary By City (Without Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Cigna 90 Now CVS - Standard - All

Distance Method
Straight Line Distance

Employee Group
All Employees

Provider Group
Cigna 90 Now CVS

Areas Without Access
Bottom 36 Cities in the market, sorted by the number of employees without access

[1] Provider counts represent:
#: Provider access points

Employees Without Access

Employee Group	537 employees 0 (0.0%) employees without access	Provider Group	62,591 unique providers at 60,955 unique locations (62,591 total access points)

Key Geographic Areas

	State Name	City	Employee	Provider		Without Access		Counts[1]	Average Distance	
			#	Group	Standard	#	%	#	1	2
Without Access	No data that meets the criteria									

Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Cigna 90 Now CVS - Standard - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Cigna 90 Now CVS

Employees With Access											
State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Broward	Fort Lauder…	33317	1	Cigna 90 Now CVS	1 in 5 miles	12	1	100.0	1.2	1.3
			33323	1	Cigna 90 Now CVS	1 in 5 miles	4	1	100.0	0.5	0.5
			33324	1	Cigna 90 Now CVS	1 in 5 miles	14	1	100.0	0.5	0.6
			33328	1	Cigna 90 Now CVS	1 in 5 miles	10	1	100.0	0.7	1.1
			33334	1	Cigna 90 Now CVS	1 in 5 miles	9	1	100.0	0.6	0.7
			33351	1	Cigna 90 Now CVS	1 in 5 miles	11	1	100.0	0.9	1.0
		Hallandale	33009	1	Cigna 90 Now CVS	1 in 5 miles	15	1	100.0	0.1	0.3
		Hollywood	33020	1	Cigna 90 Now CVS	1 in 5 miles	7	1	100.0	0.2	0.6
			33021	1	Cigna 90 Now CVS	1 in 5 miles	13	1	100.0	0.7	0.7
			33023	2	Cigna 90 Now CVS	1 in 5 miles	10	2	100.0	0.5	0.7
			33025	4	Cigna 90 Now CVS	1 in 5 miles	21	4	100.0	0.3	0.3
			33026	3	Cigna 90 Now CVS	1 in 5 miles	9	3	100.0	0.4	0.8
			33027	7	Cigna 90 Now CVS	1 in 5 miles	17	7	100.0	0.7	0.8
			33029	2	Cigna 90 Now CVS	1 in 5 miles	8	2	100.0	0.4	1.1
		Pembroke P…	33028	1	Cigna 90 Now CVS	1 in 5 miles	2	1	100.0	0.5	0.7
		Pompano B…	33073	1	Cigna 90 Now CVS	1 in 5 miles	11	1	100.0	0.5	0.9
	Flagler	Palm Coast	32137	1	Cigna 90 Now CVS	1 in 5 miles	11	1	100.0	1.4	1.4
			32164	2	Cigna 90 Now CVS	1 in 5 miles	7	2	100.0	2.0	2.4
	Martin	Stuart	34997	1	Cigna 90 Now CVS	1 in 5 miles	8	1	100.0	0.6	0.7
	Miami-Dade	Coral Gables	33114	1	Cigna 90 Now CVS	1 in 5 miles	0	1	100.0	0.0	0.5
		Hialeah	33012	4	Cigna 90 Now CVS	1 in 5 miles	28	4	100.0	0.3	0.3
			33013	4	Cigna 90 Now CVS	1 in 5 miles	8	4	100.0	0.5	0.6
			33014	3	Cigna 90 Now CVS	1 in 5 miles	11	3	100.0	0.5	0.6
			33015	2	Cigna 90 Now CVS	1 in 5 miles	11	2	100.0	0.5	0.7
			33016	1	Cigna 90 Now CVS	1 in 5 miles	16	1	100.0	0.1	0.3
			33018	7	Cigna 90 Now CVS	1 in 5 miles	8	7	100.0	0.6	0.7
		Homestead	33030	2	Cigna 90 Now CVS	1 in 5 miles	7	2	100.0	0.5	0.7
			33031	1	Cigna 90 Now CVS	1 in 5 miles	0	1	100.0	3.1	3.1
			33032	16	Cigna 90 Now CVS	1 in 5 miles	8	16	100.0	0.6	0.8
			33033	11	Cigna 90 Now CVS	1 in 5 miles	19	11	100.0	0.5	0.5
			33034	3	Cigna 90 Now CVS	1 in 5 miles	3	3	100.0	1.9	2.4
			33035	5	Cigna 90 Now CVS	1 in 5 miles	2	5	100.0	0.6	1.0
		Miami	33122	1	Cigna 90 Now CVS	1 in 5 miles	4	1	100.0	0.1	0.1
			33125	6	Cigna 90 Now CVS	1 in 5 miles	10	6	100.0	0.2	0.4
			33126	11	Cigna 90 Now CVS	1 in 5 miles	13	11	100.0	0.3	0.4
			33127	1	Cigna 90 Now CVS	1 in 5 miles	2	1	100.0	0.4	0.7
			33128	1	Cigna 90 Now CVS	1 in 5 miles	0	1	100.0	0.5	0.6
			33129	2	Cigna 90 Now CVS	1 in 5 miles	0	2	100.0	0.5	0.6
			33130	1	Cigna 90 Now CVS	1 in 5 miles	10	1	100.0	0.1	0.1
			33132	2	Cigna 90 Now CVS	1 in 5 miles	3	2	100.0	0.5	0.5

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Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Cigna 90 Now CVS - Standard - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Cigna 90 Now CVS

Employees With Access												
State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Miami-Dade	Miami	33133	16	Cigna 90 Now CVS	1 in 5 miles	8	16	100.0	0.5	0.6
			33134	37	Cigna 90 Now CVS	1 in 5 miles	9	37	100.0	0.4	0.5
			33135	7	Cigna 90 Now CVS	1 in 5 miles	15	7	100.0	0.2	0.3
			33136	1	Cigna 90 Now CVS	1 in 5 miles	6	1	100.0	0.4	0.6
			33137	2	Cigna 90 Now CVS	1 in 5 miles	9	2	100.0	0.1	0.3
			33138	1	Cigna 90 Now CVS	1 in 5 miles	3	1	100.0	0.5	0.5
			33142	9	Cigna 90 Now CVS	1 in 5 miles	13	9	100.0	0.3	0.4
			33143	15	Cigna 90 Now CVS	1 in 5 miles	8	15	100.0	0.5	0.6
			33144	6	Cigna 90 Now CVS	1 in 5 miles	15	6	100.0	0.2	0.3
			33145	9	Cigna 90 Now CVS	1 in 5 miles	4	9	100.0	0.3	0.5
			33146	12	Cigna 90 Now CVS	1 in 5 miles	2	12	100.0	0.5	0.7
			33147	13	Cigna 90 Now CVS	1 in 5 miles	4	13	100.0	0.5	0.7
			33150	2	Cigna 90 Now CVS	1 in 5 miles	5	2	100.0	0.8	0.9
			33155	36	Cigna 90 Now CVS	1 in 5 miles	16	36	100.0	0.3	0.5
			33156	9	Cigna 90 Now CVS	1 in 5 miles	8	9	100.0	1.1	1.2
			33157	21	Cigna 90 Now CVS	1 in 5 miles	13	21	100.0	0.7	0.9
			33158	3	Cigna 90 Now CVS	1 in 5 miles	0	3	100.0	0.9	1.0
			33161	4	Cigna 90 Now CVS	1 in 5 miles	5	4	100.0	0.5	0.5
			33162	1	Cigna 90 Now CVS	1 in 5 miles	8	1	100.0	0.2	0.3
			33165	18	Cigna 90 Now CVS	1 in 5 miles	16	18	100.0	0.4	0.5
			33166	4	Cigna 90 Now CVS	1 in 5 miles	2	4	100.0	0.7	0.9
			33167	2	Cigna 90 Now CVS	1 in 5 miles	1	2	100.0	0.9	1.4
			33168	5	Cigna 90 Now CVS	1 in 5 miles	3	5	100.0	0.8	0.9
			33169	2	Cigna 90 Now CVS	1 in 5 miles	11	2	100.0	0.5	0.5
			33170	6	Cigna 90 Now CVS	1 in 5 miles	2	6	100.0	1.0	1.5
			33172	5	Cigna 90 Now CVS	1 in 5 miles	8	5	100.0	0.5	0.6
			33173	10	Cigna 90 Now CVS	1 in 5 miles	6	10	100.0	0.3	0.4
			33174	10	Cigna 90 Now CVS	1 in 5 miles	13	10	100.0	0.3	0.4
			33175	9	Cigna 90 Now CVS	1 in 5 miles	11	9	100.0	0.3	0.6
			33176	15	Cigna 90 Now CVS	1 in 5 miles	10	15	100.0	0.7	1.2
			33177	19	Cigna 90 Now CVS	1 in 5 miles	10	19	100.0	0.5	0.7
			33178	3	Cigna 90 Now CVS	1 in 5 miles	11	3	100.0	0.4	0.6
			33179	3	Cigna 90 Now CVS	1 in 5 miles	3	3	100.0	0.7	0.9
			33182	5	Cigna 90 Now CVS	1 in 5 miles	0	5	100.0	1.3	1.5
			33183	5	Cigna 90 Now CVS	1 in 5 miles	5	5	100.0	0.7	1.3
			33184	2	Cigna 90 Now CVS	1 in 5 miles	5	2	100.0	0.5	0.6
			33185	1	Cigna 90 Now CVS	1 in 5 miles	8	1	100.0	0.4	0.4
			33186	24	Cigna 90 Now CVS	1 in 5 miles	15	24	100.0	0.4	0.6
			33187	10	Cigna 90 Now CVS	1 in 5 miles	4	10	100.0	1.5	3.2
			33189	8	Cigna 90 Now CVS	1 in 5 miles	8	8	100.0	0.6	0.7

Continued on next page...

Access Detail By Zip Code (With Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Cigna 90 Now CVS - Standard - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Cigna 90 Now CVS

Employees With Access											
State Name	County	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
Florida	Miami-Dade	Miami	33190	2	Cigna 90 Now CVS	1 in 5 miles	1	2	100.0	0.6	0.9
			33193	17	Cigna 90 Now CVS	1 in 5 miles	5	17	100.0	0.4	0.4
			33194	2	Cigna 90 Now CVS	1 in 5 miles	0	2	100.0	1.2	1.2
			33196	5	Cigna 90 Now CVS	1 in 5 miles	12	5	100.0	0.7	0.8
			33255	1	Cigna 90 Now CVS	1 in 5 miles	0	1	100.0	0.6	0.6
		Miami Beach	33139	1	Cigna 90 Now CVS	1 in 5 miles	16	1	100.0	0.3	0.3
			33141	1	Cigna 90 Now CVS	1 in 5 miles	7	1	100.0	0.1	0.4
			33154	1	Cigna 90 Now CVS	1 in 5 miles	4	1	100.0	0.2	0.2
		Miami Gard…	33056	1	Cigna 90 Now CVS	1 in 5 miles	6	1	100.0	0.6	0.9
		Opa Locka	33054	2	Cigna 90 Now CVS	1 in 5 miles	4	2	100.0	0.4	0.8
			33055	3	Cigna 90 Now CVS	1 in 5 miles	5	3	100.0	0.6	0.7
	Monroe	Key Largo	33037	1	Cigna 90 Now CVS	1 in 5 miles	4	1	100.0	2.6	4.5
		Marathon	33050	1	Cigna 90 Now CVS	1 in 5 miles	4	1	100.0	0.3	2.2
	Palm Beach	Lake Worth…	33460	1	Cigna 90 Now CVS	1 in 5 miles	6	1	100.0	0.1	0.1
		Pahokee	33476	1	Cigna 90 Now CVS	1 in 5 miles	1	1	100.0	0.4	9.0
	Polk	Kissimmee	34759	1	Cigna 90 Now CVS	1 in 5 miles	1	1	100.0	2.1	2.2
	St. Lucie	Port Saint L…	34953	2	Cigna 90 Now CVS	1 in 5 miles	7	2	100.0	1.1	1.4
Georgia	Houston	Kathleen	31047	1	Cigna 90 Now CVS	1 in 5 miles	1	1	100.0	2.5	2.6
	Lowndes	Valdosta	31605	1	Cigna 90 Now CVS	1 in 5 miles	2	1	100.0	1.4	3.9
Oregon	Jackson	Medford	97504	1	Cigna 90 Now CVS	1 in 5 miles	14	1	100.0	0.7	0.8
South Carolina	Greenville	Travelers Rest	29690	1	Cigna 90 Now CVS	1 in 5 miles	5	1	100.0	2.4	2.5
Tennessee	Sumner	Gallatin	37066	1	Cigna 90 Now CVS	1 in 5 miles	15	1	100.0	0.3	0.4
Washington	Pierce	Tacoma	98404	1	Cigna 90 Now CVS	1 in 5 miles	3	1	100.0	0.7	0.9
Grand Totals				537	Cigna 90 Now CVS	1 in 5 miles	788	537	100.0	0.5	0.8

Access Detail By Zip Code (Without Access)

July 2024

Created for...
City of Coral Gables

Access Analysis
Cigna 90 Now CVS - Standard - All

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Cigna 90 Now CVS

Employees Without Access											
State Name	County	City	Zip Code	Employee	Provider		Counts	Without Access		Average Distance	
				#	Group	Standard	#	#	%	1	2
No data that meets the criteria											

Access Detail By Zip Code (Excluded from Analysis)

July 2024

Created for...
City of Coral Gables

Access Analysis
Invalid Zip Codes

Distance Method
Straight Line Distance

Employee / Provider Groups
All Employees
Cigna 90 Now CVS

Employees Excluded from Analysis	
Zip Code	Employee #
No data that meets the criteria	

As Cigna Healthcare is the incumbent carrier, there are no restrictions or exclusions imposed to this project and proposed approach and methodology. We have matched the benefits that we are currently administering for the City of Coral Gables.

We did provide alternative plan designs as requested per the RFP.

Cigna's eligibility system is a single-source repository that ensures quick and accurate uploading, maintenance, and management of critical member information and is accessible by multiple internal systems. The eligibility system is the key to efficiently processing claims and to convenient client self-service (e.g., internet enrollment). Created by Cigna architects and developers, our eligibility system is the single source for loading, maintaining, and tracking eligibility information; PCP changes; member demographics; member-level plan changes; and HIPAA privacy information (also known as member rights repository). It creates a unique Cigna ID for use throughout the Cigna eligibility environment. The City may submit automated eligibility files (showing coverage choices and custom coverage) through several external access methods (determined by client need). The database supports the coordination of the coverage agreement, endorsed individual part D plans, Medicare Part D, Medicare Rx, and Voluntary Data Sharing Agreement membership through interfaces to Medicare.
The eligibility system is accessible through our client website or the enrollment maintenance tool (EMT) for update capability.
Our eligibility system

- maintains data integrity across plans;
- eliminates Cigna-generated disjoint risks;
- captures member information (new or maintenance) and links it to applicable systems and applications;
- creates a single set of tools for managing client files and loading and maintaining eligibility data;
- enables easier access to member eligibility data held in Cigna systems; and
- facilitates self-service inquiry, internet enrollment, and other service features.

The City can continue to access our online enrollment maintenance tool (EMT) through our client website to enhance administrative efficiency. This tool streamlines the eligibility process and includes a series of automated eligibility reports.
With the EMT, clients can

- make real-time changes to eligibility information;
- enroll new employees and dependents at any time;
- cancel coverage for employees;
- add dependents;
- change elections; and
- change member demographics, such as gender, age, and address.

Clients can also manage their automated eligibility process online, which includes the following:

- tracking the status details of a file through automatic email notifications with several options distributed in real time
    - notice of delinquent file
    - notice edit reports published
    - notice file held for review
    - notice eligibility file received and updated
    - viewing member coverage information, as allowed by HIPAA

EXHIBIT G
GROUP BENEFITS QUESTIONNAIRE

Group Benefits Questionnaire: Provide responses, attach additional pages if necessary.

Medical Coverage

Administration

1) Please confirm that all employees and dependents will enter the plan on a no loss, no gain basis (continuity of coverage).

   Response: **Confirmed.**

2) Please confirm that your company will waive the "actively at work provision".

   Response: **Confirmed.**

3) Will your company waive dependent non-confinement limitations provisions for all currently enrolled individuals on medical?

   Response: **Confirmed.**

4) Please confirm that medical underwriting will not be a requirement for future employees of the City of Coral Gables.

   Response: **Confirmed.**

5) Will your company guarantee proposed rates for longer than 12 months? What type of rate cap can be offered for subsequent years?

   Response: **We do not guarantee rates on fully insured business for more than 12 months.**

6) Will your company be willing to provide a renewal offer at least 120 days prior to the renewal effective date?

   Response: **Typically, Cigna supplies renewals 90-120 days before the renewal date. We review rates at least 60 days before the established rate option date, or further in advance as required by state law or plan design. This may or may not coincide with the policy anniversary date.**

7) How often do you negotiate provider contracts for your HMO/POS network?

Response:

By investing in our valued provider relationships and collaborating to achieve sustainable agreements that support our mutual members, we remain committed to keeping our provider partners in network. Cigna Healthcare's contracts are evergreen and typically renegotiated every 2-3 years. This contracting approach provides an opportunity to respond to external dynamics and to the most current competitive intelligence.

In 2023, we saw an increase in providers opening deals early, and the industry as a whole saw an increase in provider negotiations that approached a potential termination. Our goal is to minimize disruption by keeping providers in our network at rates that are affordable and sustainable for our clients, their employees, and their families. We have nearly 6,000 hospitals in our network, of which 326 have pending negotiations.[1] In an average year, 98.4% of these negotiations are resolved without mailing members letters.[1] In addition, only 0.4% of these hospitals go out of network for any period of time and only 0.2% remain out of network.[1]

(1) Based on average of Cigna Healthcare negotiations between 2021 – 2023.

8) Confirm that your company will not be paying commissions/service fees in association with this submission.

Response: **Confirmed. Our offer is net of commissions, renewal is net of commissions.**

11) Please provide a timetable that will outline the necessary requirements to implement your program for a January 1, 2025, effective date.

Response: **Please refer to Section III for the implementation timetable.**

12) Please confirm that your firm is responsible for mailing all communications to members such as HIPAA required certificates of coverage.

Response: **Confirmed. We will be responsible for mailing all applicable, required plan communication to the City's members. However, please note that Cigna no longer provides HIPAA certificates of creditable**

coverage as of January 1, 2015, as the Affordable Care Act (ACA) prohibited preexisting condition limitation provisions beginning in 2014 and such documentation is no longer required. For participants who wish to have written proof of their coverage, Cigna Customer Service is able to issue a standard eligibility letter upon request that includes eligibility effective and termination dates, sufficient for most administrative purposes or related needs.

13) What is your company doing to keep your clients informed and compliant with current/changing legislation?

Response: **We have an extensive legal and compliance staff to address legal, legislative, and regulatory matters. Our state and federal regulatory compliance department monitors legislative, market, and industry trends. The City will be promptly notified of legislative changes that materially affect our ability to provide client and member services. The client manager can assist with any technical questions from the City; however, we do not provide legal counsel to clients. The City is responsible for seeking its own advice if consultative services are required.**

14) Please confirm that you have the technological capacity to transmit and accept HIPAA 834 5010 eligibility file with proper confirmation of receipt and discrepancy reporting. Does your enrollment system allow enrollment of multiple lines of coverage?

Response: **Confirmed.**

Billing

1) Can the City of Coral Gables perform additions and terminations online? How long does it take for these changes to appear on your system?

Response: **Yes. The City can continue to access our online enrollment maintenance tool (EMT) through our client website to make real-time changes to eligibility information including additions and terminations.**

2) Does the City of Coral Gables take credit immediately for any differences in the billing, or do they need to pay as billed and receive credit in the future?

Response: **The City will continue to receive a monthly bill showing the premium due for the coverage month and any retroactive adjustments.**

We do not prorate, instead we use the wash method as described below to calculate the billing census:

- **If the member is added with an effective date on or before the 15th of the month, then payment is needed for the entire month.**
- **If the member is added with an effective date on or after the 16thof the month, then no payment due for the effective month. Full payment is due for the following month.**
- **If the member terminates on or before the 15thof the month, then no payment is due for that covered month.**
- **If the member terminates on or after the 16thof the month, then payment is needed for the entire month.**
- **If the member changes with an effective date on or before the 16th of the month that result in a rate change, then the new rate line is owed for that month.**
- **If the member changes with an effective date after the 16th of the month that results in a rate change, then the new rate changes is effective the first of the following month.**

3) Can the City be administered on a self-billing basis?

Response: **Yes. Your account manager will be happy to discuss the client-driven remittance option with the City.**

4) Can monthly invoices be sent electronically?

Response: **Yes. PDF versions of monthly invoices are available on our client website.**

5) Can employees be retroactively cancelled? If so, how far back?

Response: **Yes. Our retroactive termination policy limits our financial responsibility for member termination submissions to 60 days before the City notifies us of the termination. If notified within 60 days, we return the payments that we have collected for the members whose coverage has ended. If we receive notification after 60 days from the date of termination, the payments are not returnable. We provide 60 days of credit from date of termination request. If the request is made outside of 60 days, we will return premiums for the last 60 days.**

6) Can your bill break out employees by department? location? retirees?

Response: **Yes. Cigna can subdivide the monthly statement into groups, referred to as branches. Our systems can accommodate up to 992**

branches per account number. Service fees apply if additional lines of structure are required. If an account is set up with a different statement for each branch, we can bill individually (and still consider it one account).

Claims Administration

1) Is there a Customer Service number which City of Coral Gables employees may call directly?

Response**: Yes. The City's members can continue to access our specialized customer service team by calling 800.Cigna24 or the toll-free number on the back of their ID card.**

2) What are the days and hours of operation for the call center?

Response: **Our specialized customer service team will continue to provide support to your employees and their families 24 hours a day, 7 days a week, 365 days a year. The City membership will be serviced by our Smart Support service team, who have deep knowledge of plan benefits, located throughout the US, from 8:00 a.m. to 8:00 p.m. (EST). After hours and weekend/holiday support is provided by our extended service team.**

3) Will your claims processors undergo a major change in office location or claim payment system in the next 18 months?

Response: **There are no plans currently to replace our claim processing system or change claim office location. In addition, we are constantly modifying our claim system to improve operational efficiencies and leverage technology to support both our clients' and members' needs as effectively and efficiently as possible.**

4) Will you allow the Employer's third-party auditors to periodically audit claim payments? Yes_____No_**X**___

Under a fully insured arrangement, Cigna is fully responsible for claims administration. and carries all risk associated with such processes; therefore, external audits are not permitted, except when required to comply with applicable law. Performed audits must be in accordance with Cigna's audit requirements. Cigna has an internal claim quality assurance program to monitor conformance with internal performance standards to ensure the accuracy of claims payment.

5) Can employees sign up for an account on your website to track the claims process for themselves and their dependents?
Response: **Yes. Our member website, myCigna, is a real-time application. As such, members can continue to view new claim information online as soon as claims are processed.**

Management Reporting

1) a) Can you provide online claims data? Yes__X__ No_____
b) Is the online data real time? Yes__X__ No_____
c) Is there an additional charge for this? Yes_____ No__X__
d) Is this amount included in the quoted rates? Yes__X__ No_____

2. Describe the reports you will provide regarding the utilization and claims associated with the employee benefits program(s) you are proposing. Please indicate in your description if any of the reports would be provided at an additional cost over the fees associated with the programs.

Response: **Cigna's approach to analysis and reporting is to provide industry-leading reporting capabilities supported by consultation. This approach delivers value to the City by assessing performance across critical dimensions, including operational effectiveness, strategic opportunities, and outcomes evaluation. Our standard reporting package, included at no additional cost, will continue to empower the City to make decisions that will improve employee health and maximize their health care investment's performance. In short, we deliver the data insights that matter.**

Annual Consultative Report
Our account management team will continue to meet with the City annually to review its personalized reporting package, which is produced through our industry-leading analytics tools. This report capability is based on a data model that accumulates information at a member level across eligibility, claims, clinical outcomes, and individual interactions. Our annual consultative report delivers value to our clients by assessing performance across three critical dimensions:
• Operational Effectiveness - Is the plan performing optimally?
• Strategic Opportunities - Are there investment opportunities to mitigate plan cost and improve member health?
• Outcomes Evaluation - Is Cigna delivering value for the programs and solutions that are in place?This reporting capability is flexible, and we can tailor it to address The City's key areas of interest.
Quarterly Utilization Reports

Utilization reports allow the City to view and analyze cost and utilization data for medical and pharmacy plans. By applying integrated, in-depth medical and pharmacy data analysis, utilization reports provide practical and actionable information that demonstrates the value of our plans and services and helps the City control medical cost trends. Utilization data is updated quarterly and is available on our client website.

Monthly Financial Reports
We update our web-based financial experience reports monthly and design them to help the client monitor plan performance. We design the financial reports to provide detailed accounting of paid claims during a policy period to help manage finances and plan for health coverage expenditures. Data in these reports is based on the City's policy year. Our monthly financial reports are available through our client website.

Eligibility Reports
Our client website offers a separate, online eligibility-reporting tool. The tool can generate more than 20 different kinds of reports, including account structure, additions, cancellations, student status, and member listings. Eligibility data is updated in real time.

3. What is your proposed frequency of reporting on utilization experience? Is there a charge for utilization data analysis?

   Response: **Utilization management reports may be available online through our client website. We provide these reports at the City's request (at no additional cost). The standard availability for online reports is 45 days after the close of the quarter.We base our standard utilization reports on 36 months of recent data (24 months plus current YTD). The majority of our standard reports include 12-month period-to-period comparisons.**

4. Are there any additional fees for reporting? Please provide all reporting options/packages and their associated costs.

   Response: **The City will continue to receive our standard reporting package at no additional cost. In the event that standard reporting does not meet your needs, we offer ad hoc reporting. The standard charge for additional ad hoc utilization reporting and consultative services is $300 for up to one hour of work and $175 per additional hour. Fees for customized utilization reports vary based on the nature and complexity of the request. We can provide specific pricing upon request.**

5. Will there be online access for claim administration and reports for the Entity?

Response: **Confirmed.**

6. Will there be online access for claim administration by the broker, Gehring Group, a Risk Strategies Company?

Response: **Yes. With approval from the City, Cigna can grant brokers and consultants access to the website.**

Provider Network

1) Does your company have guidelines in place whereby participating physicians are required to send patients to third parties for necessary lab work?

Response: **Yes. We require participating health care providers to refer members to in-network providers and facilities, including our preferred national ancillary providers (e.g., Quest Diagnostics, LabCorp); however, PCPs are not gatekeepers in open access plans. They provide preventive and routine medical care, advice, and direction. Members may visit a specialist or other in-network doctors without obtaining a referral.**

2) What percentage of the physicians in your network can handle lab work in their office?

Response: **Cigna does not track the percentage of providers that can handle lab work in their office.**

3) Please identify your preferred lab vendor.

Response: **For over 15 years, we have had contracts with both LabCorp and Quest Diagnostics, which is unique in the industry. We require participating health care providers to refer members to in-network providers and facilities, including our preferred national ancillary providers (e.g., LabCorp, Quest Diagnostics). We remind providers of the requirement to refer members to in-network labs and educate them on local in-network options.In addition, we accept lab results from several vendors, including LabCorp and Quest Diagnostics.**

4) How does portability of benefits work for insureds traveling or living outside the South Florida area? Please confirm your provider network is a national network. If not proposing a national network coverage, please describe

available access for out-of-state residents (retirees and/or dependents of covered participants)

Response: **Confirmed. Cigna's provider network is a national network.**

The City's members will continue to have direct access to our broad, national Open Access Plus (OAP) health care professional network and have the option to make their own health care choices. Eligible members and dependents may visit any participating network health care professional to receive in-network coverage. Members can access care without a referral; some services and procedures may still require health care professionals to obtain precertification from Cigna. Cigna members can also choose to visit an out-of-network health care professional at any time at out-of-network coverage levels. Members can obtain participating health care professional information from our website or by contacting customer service.

In the case of an emergency, we encourage members to seek care at the closest appropriate health care facility. We cover emergency care at the in-network coverage level. We use prudent layperson criteria when defining an emergency.

For plans with out-of-network coverage, we pay services deemed as emergency care at the in-network coverage level. For plans with only in-network coverage, we also pay emergency care services provided at out-of-network facilities at the in-network coverage level.

5) Please describe your referral process from PCP to Specialist. Are certain specialists precluded from the referral process?

Response: **The City's Open Access Plus (OAP) plan is an open access program, as such no referrals are required to access services from specialists. We cover members whether they receive care from in- or out-of-network health care providers; however, receiving care from OAP providers enhances their coverage. Admission to a participating or nonparticipating hospital requires prior authorization by our health facilitation center.**

6) Please confirm proposer has included telemedicine benefit in quote.

Response: **Confirmed. Our virtual care solution includes services offered through Cigna Healthcare network health care providers and through our partnership with MDLIVE. Services include urgent care, primary care (wellness screenings and routine care with chronic condition management and digital health coaching), specialty care (dermatology), and behavioral care (therapy and psychiatry). Members have access to private, live appointments through secure video or phone with board-certified doctors who are able to diagnose and prescribe (when**

appropriate). Members are able to choose the time and day that works best for them, with virtual minor medical services available 24 hours a day, 7 days a week, 365 days a year. Appointments are required for behavioral care and virtual wellness screenings.
In addition, digital physical therapy through RecoveryOne is a standard program available to medical clients, regardless of funding type, at no additional cost to the client or member. The RecoveryOne program is available to medical subscribers and dependents age 18 and older. RecoveryOne enables members to recover more quickly, safely, and conveniently. RecoveryOne is not bound by a prescribed number of visits or inflexible benefit design, but rather consists of dynamic recovery pathways that help members get back to a better quality of life at their convenience. Members take charge of their recovery from the convenience of home, using clinically proven care pathways designed for any part of the body from the neck down. RecoveryOne personalizes the solution to the member, including a virtual physical therapy assessment with a licensed physical therapist, behavior change support, exercise equipment kit, and an app for on-demand recovery sessions. Digital sessions are optimized to member needs and adjusted based on their progress and feedback. The result is timely and accessible care that reduces the cost burden and makes your employees happier and healthier.

7) Are members required to select a PCP? Yes____ No_**X**__

8) Provide a list of services that require pre-authorization.

Response: **We require precertification of elective non-obstetrical inpatient admissions. Also, we maintain a standard list of outpatient services and supplies that require precertification of coverage under Health Matters Care Management Preferred medical management model. This list of high-cost/high-frequency services, some of which are associated with overutilization or inappropriate utilization, is continually reviewed and updated as we receive new data and research. We focus our clinical review resources where they will have the most impact on improving quality outcomes and reducing costs.The outpatient services and procedures that generally require medical necessity review include the following:**

- **DME (no dollar threshold under which we do not pre-certify)**
- **gastroenterology services (e.g., endoscopy, capsule endoscopy)**
- **genetic testing**

- **high-tech imaging (e.g., CT scans, PET scans, MRIs, diagnostic cardiology)**
- **home health care**
- **home infusion therapy**
- **infused/injectable medications**
- **medical oncology**
- **musculoskeletal services (e.g., major joint surgery and pain management services)**
- **outpatient surgery for selected procedures**
- **potentially cosmetic procedures**
- **potentially experimental/investigational/unproven procedures**
- **private duty nursing**
- **radiation therapy**
- **sleep management**
- **specified diagnostic procedures**
- **transplant services**
- **unlisted procedures**

We also review certain services or procedures delivered on an outpatient basis that would require review if they were delivered on an inpatient basis. For example, we may review bariatric surgeries for medical necessity regardless of the procedure setting.When deciding which outpatient supplies and services to include on the precertification list, we consider the following:

- **potential for overutilization**
- **specific plan exclusions that may apply**
- **opportunity for redirecting to preferred vendors**
- **opportunity for potential case management**
- **overall coverage plan cost savings opportunity**

9) Does the PCP act as a “gate keeper” or is your quotation an open access network? ___Gate Keeper __X__Open Access

10) How frequently may they change their PCP? Can the member change PCP’s via your website?

Response: **Members in an Open Access Plus (OAP) plan may choose to establish a relationship with a particular PCP. If a member decides to change doctors, he or she simply chooses another doctor.**
Members may call our toll-free customer service number at any time with questions or concerns about network doctors. We also offer the health information line, staffed by RNs who can access network and coverage information.In addition, members can change their doctor by phone or through the member website, myCigna.

11) Please provide a GEO Access report.

Response: **Please refer to the GEOAccess report provided in Section III of this proposal.**

12) What happens if a network provider refers a member (without member’s knowledge) to a nonparticipating provider? Who is at risk?

Response: **In certain cases, we will cover necessary treatment by an approved out-of-network health care provider at the in-network level when prior approval has been received from Cigna. If a member uses an out-of-network provider without first receiving prior approval, out-of-network coverage levels will apply.**
In-network providers are contractually obligated to refer members to other in-network providers. The member is responsible for ensuring that the doctor to whom he or she was referred is in-network. There are no penalties in place for primary care network providers who refer out-of-network; however, our contracts require that providers refer patients to in-network providers only. While, our contracts do not allow us to impose any financial penalties. If a provider has a history of referring to out-of-network providers and he or she does not change these referral patterns after multiple consultations with our provider services team, the provider can be terminated.

13) Is your plan licensed by the State of Florida? Yes__X__No____

If no, when did you apply and what is its status?

Response: **Not applicable.**

14) Please fill in the following table showing the number of network providers in the specific counties:

		HMO	PPO
Miami-Dade			
	PCPs	**1,710**	**5,976**
	Pediatricians	**450**	**1,202**
	OB/GYN	**286**	**1,047**
	Urgent Care Facilities	**64**	**81**
	Lab Facilities	**44**	**40**
	Hospitals	**44**	**45**
	Pharmacies	**575**	**575**
Broward			
	PCPs	**1,075**	**3,097**
	Pediatricians	**216**	**898**
	OB/GYN	**227**	**833**
	Urgent Care Facilities	**73**	**78**
	Lab Facilities	**38**	**43**
	Hospitals	**36**	**41**
	Pharmacies	**427**	**427**

15) If an employee/dependent is currently pregnant will they be allowed to continue with their current physician should that physician not be in the network?

Response: **Transition of Care (TOC) does not apply to someone who has been an enrolled Cigna member during the previous contract period; however, if a member or spouse/partner/dependent of an existing Cigna member is first added to a Cigna plan at the time of contract renewal, that person would be a new member for that plan year and would be eligible for TOC consideration. Cigna makes every effort to manage the member's transition of care (TOC) from a nonparticipating health care provider to avoid a disruption of services that may impact the member's health status. There are no additional fees for these services. Members must apply in writing for in-network-level TOC within 30 days of enrollment in the health plan (unless the applicable state mandates a longer period). If Cigna approves coverage, a member may continue to receive services from that doctor, hospital, or other provider for a specified period with covered services paid at the in-network coverage level. Members may contact a One Guide personal guide for assistance with completing the TOC application. The personal guide records the information the member provides and submits the application on his or her behalf.**

Review Process
As a first step in the review process, the TOC request is examined to see whether it meets certain criteria. Conditions that may qualify for TOC coverage include second or third trimester of pregnancy as of the start date of coverage. If the TOC request meets the inclusion criteria, Cigna may complete a medical necessity review upon receipt of the clinical information from the member or provider and may make a determination about coverage of the above services.

Unless otherwise required by applicable state mandates, which always take precedence, TOC approvals apply to an appropriate period following the member's start date (e.g., 30, 60, or 90 days) or until the member completes care or transitions to a participating doctor, hospital, or other provider or exceeds coverage limitations, whichever occurs first. Approvals do not generally exceed 90 days.

16) Please provide sample benefit booklets, communication materials, and specimen contracts. Also please confirm that these materials are included as part of your proposal submission. The City will require bi-lingual staff and materials.

Response: **The requested materials have been provided in the Exhibits section of this proposal.**

17) What has been your book of business rate increase for:

	HMO	PPO
2021	*	*
2022	*	*
2023	*	*
2024	*	*

***We do not disclose our book of business rate increases, please refer to the current trend factors in our response to Question 21.**

18) What are your current trend factors?

HMO _____
PPO _____
Rx _____

Prospective trend projections are a function of unit cost changes expected on provider contractual arrangements and utilization based on macroeconomic factors. Key factors impacting trend in 2024 through 2025 are:

- **Elevated unit costs resulting from inflationary pressure on the health system;**

- **Continued increase in expected behavioral trends;**
- **Reduced steerage opportunities as utilization management programs mature; and**
- **Incremental improvement driven from enterprise affordability initiatives.**

19) What is your company's acceptable loss ratio for an account of this size? Does your proposed funding fall within this range?

Response: **A range of 85%-90% based on funding and expenses.**

20) Have there been any changes to your South Florida network in the past three years?

Response: **Our networks have been very stable in South Florida over the past three years.**

21) Are there any hospitals in the South Florida area with which you are not contracted? If yes, list such hospitals.

Response:

HOSPITAL NAME	ADDRESS	CITY	STATE	ZIP	COUNTY
BROWARD HEALTH CORAL SPRINGS	3000 CORAL HILLS DRIVE	CORAL SPRINGS	FL	33065	BROWARD
BROWARD HEALTH IMPERIAL POINT	6401 NORTH FEDERAL HIGHWAY	FORT LAUDERDALE	FL	33308	BROWARD
BROWARD HEALTH MEDICAL CENTER / SALAH FOUNDATION BROWARD HEALTH CHILDRENS HOSPITAL	1600 SOUTH ANDREWS AVENUE	FORT LAUDERDALE	FL	33316	BROWARD
BROWARD HEALTH NORTH	201 E SAMPLE RD	DEERFIELD BEACH	FL	33064	BROWARD
LARKIN COMMUNITY HOSPITAL	7031 SOUTHWEST 62ND AVENUE	SOUTH MIAMI	FL	33143	DADE
LARKIN COMMUNITY HOSPITAL PALM SPRINGS CAMPUS	1475 WEST 49TH STREET	HIALEAH	FL	33012	DADE
HCA FLORIDA PLANTATION EMERGENCY	401 NORTHWEST 42ND AVENUE	PLANTATION	FL	33317	BROWARD

22) Describe in detail, your out-of-area coverage for dependent students attending school out of area. Include your procedures for emergency care, as well as follow-up visits.

Response: **Our Open Access Plan (OAP) plan offers a national network that**

allows members to access care at in-network levels from OAP health care providers in any of our local networks when away from home. Dependents living away from home can access care from local OAP providers. Members can obtain participating provider information from our website or by contacting customer service. In the case of an emergency, we encourage members to seek care at the closest appropriate health care facility. We cover emergency care at the in-network coverage level. We use prudent layperson criteria when defining an emergency. For plans with out-of-network coverage, we pay services deemed as emergency care at the in-network coverage level. For plans with only in-network coverage, we also pay emergency care services provided at out-of-network facilities at the in-network coverage level.

General

1) Are there any year-end charges that could be incurred by the City of Coral Gables due to higher than expected plan utilization?

   Response: **Fully Insured plus coverage does not have any deficit carryforward.**

2) Assuming a January 1st effective date, when can the City of Coral Gables expect to receive I.D. cards, booklets, plan documents, etc.

   Response: **ID Cards**
   Members will continue to receive ID cards via USPS first-class mail approximately 7–10 business days after the eligibility data provided by the City has been accepted and processed. Upon the completion of loading eligibility into Cigna systems, temporary ID cards are immediately available through our member website, myCigna, and on mobile-enabled devices through our myCigna mobile app.

   Booklets/Certificate of Coverage
   As a fully insured client, the City will continue to receive a copy of the certificate of coverage electronically via PDF at no additional cost (we cannot provide it in Word format); however, there may be additional fees if the City requests numerous nonstandard modifications. The certificate of coverage reflects the client's insurance coverage and contains federal and state requirements applicable to insured accounts. In addition, we would be happy to work with the City to address the need for certificates of coverage in languages other than English. We contract with a vendor for printing and distribution of certificates of coverage at no additional cost to the client; however, additional fees may apply for shipping to multiple locations or members.

Provided critical case submission materials are provided in a timely manner, we will provide the client with draft copies of both the master policy and the certificate booklet within approximately 30 days of the plan's start date, or earlier if required by state law. Note that we have filed entire certificates for Connecticut, Maine, Maryland, New Jersey, New Mexico, North Carolina, Oregon, and Tennessee, and we cannot make changes to certificates issued in those states. Under the 1997 HIPAA requirements, communication of coverage to the member must occur within 60 days of the start date of the plan. We send certificates to clients for review within 60 days after the start date. When the client approves the certificate, we print and mail it to the client, who then distributes it to employees.

Communication Materials
Communication materials, based on the City's plan offerings and needs, are a standard part of our account implementation process.
Preenrollment materials may include the following:

- **an enrollment application**
- **a Certificate of Coverage**
- **HIPAA special enrollment rules**
- **medical, pharmacy, dental, and/or vision brochures**
- **information on additional resources and services (e.g., health information line, health assessments, cost and quality tools)**

Post enrollment materials may include the following:

- **a myCigna flyer**
- **Cigna Pharmacy brochures and order forms**
- **other consumer health engagement brochures and materials (depending on coverage)**
- **ID cards (mailed separately)**

Cigna delivers standard printed materials to the City approximately 10–15 business days after placing the order.

3) Do you agree to allow retirees over and under 65 to continue coverage under the same plan at the same rate as active employees as required by Section 112.08, Florida Statutes, for public entities?

Response: **Yes.**

4) Provide the name, title, and contact information of the individual who would have direct daily account responsibility for the services you are proposing. If more than one person will be filling this role, please respond with complete information for all.

Response: **Dina D'Angelo is City of Coral Gables's assigned Senior Client Manager. Dina collaborates with the City to execute the overall benefits strategy, implementation, and account management and is responsible for**

medical, pharmacy renewals and reporting functions. Dina can be reached at 954-790-8152 or Dina.D'Angelo@cignahealthcare.com

Joyce Lau is City of Coral Gables's assigned Client Account Manager. Joyce partners with Dina as an additional resource for account management administration. Her responsibilities include renewal implementation, client reporting and working closely with departments across the organization to address and resolve operational concerns impacting client satisfaction. Joyce can be reached at 954-514-6767 or at Joyce.Lau@cignahealthcare.com.

John Kura is City of Coral Gables's assigned Client Service Executive (CSE). John is the direct point of contact for escalated call, claim, billing, and eligibility questions. John can be reached at 860-787-7911 or at John.Kura@cignahealthcare.com.

5) What is your account service team's average response time to client requests or questions?

Response: **Your account management team will continue to act as an extension as the City benefits team, with most inquiries being completed or resolved at the time of inquiry, or same day. Urgent inquiries will receive an acknowledgement of receipt from our team typically within two hours; routine inquiries will receive acknowledgement within 24 hours. Our acknowledgement responses will identify any next steps or additional information that may be needed and will provide an estimate of time to resolve your inquiry. While those are the typical response times, we are willing to work together to customize a mutually agreeable arrangement for response times, if desired.**

6) Does your company offer a Wellness Program? If so, please describe it.

Response: **Yes. Better health isn't just a goal, it's essential to the vitality of your workforce. We're giving your employees the tools they need to be their best through our new Cigna Healthcare℠ Well-Being Solution. The holistic and personalized Well-Being Solution provides a personalized, best-in-class experience to help individuals make small, everyday changes to their well-being focused on areas that they want to improve the most.**

Available in over 21 languages and seamlessly connected via myCigna, our innovative platform includes the following features that work in concert with one another:

- **an expansive, evidence-based educational content library capturing 29 health topics;**
- **optional best practice incentive plans that are available to drive ongoing engagement;**
- **approximately 2,800 digital cards that improve well-being literacy and inspire new behaviors with micro-learning content;**
- **AI-driven recommendations designed to reinforce more than 480 healthy habits;**
- **digital guides capturing sleep and nutrition tips, tricks, and tracking, allowing personalized action plans;**
- **health risk assessment and survey tools, certified by the National Committee for Quality Assurance (NCQA);**
- **well-being challenges, including peer-to-peer challenges, monthly healthy habits challenges, and 3 Cigna challenges;**
- **device integration with any device, app, or tracker that connects to Apple® Health app or Google Fit®;**
- **social connections, allowing members to invite up to 10 family members/friends to share in the experience;**
- **a total of 60 digital health coaching journeys that help members improve their health literacy and form new habits naturally;**
- **a My Care checklist that can be updated by the member to track preventive screenings and set reminders; and**
- **automated communications and engagement campaigns.**

When the City's employees utilize the program over time, they build healthy habits, have fun with friends and family, and experience the lifetime rewards of better health and well-being.

We pair this offering with our team of highly trained health engagement consultants who are available to work personally with the City to build holistic and inclusive health engagement strategies beyond the traditional dimensions of well-being. We leverage actionable insights from social determinants of health data, analytics from claims, biometrics, health

assessments, and interaction data to guide data-driven decisions and ensure a highly personalized plan. Member tools and resources allow the City's employee population to see measurable results. Together, we will help guide your employees to a healthier way of life, and our team of experts can help the City's increase the health engagement of the population steadily, year after year.

7) Please describe your companies Employee Assistance Program? Please describe (i.e. is it telephonic or referral/in-person).

Response: **Access to our EAP services is available online and via our toll-free number 24 hours a day, 7 days a week, 365 days a year. Individuals can receive an assessment and, if necessary, a referral to an EAP provider for up to three visits per issue per participant per year. Our EAP services fall into three categories:**

- **employee services**
- **management services**
- **organizational services**

- **A list of the services within each category is included below.**
- **Employee and household member services include the following:**
- **assessment and referral services as follows:**
- **unlimited consultation with telephonic EAP consultants (licensed clinicians)**
- **live chat for EAP support and referral services through myCigna**
- **find-a-provider service**
- **face-to-face or virtual care sessions with an EAP provider**
- **includes access to Talkspace, an in-network provider, for video-based and/or text therapy (to count toward the available number of sessions)**
- **creation of action plans**
- **referrals to MHSUD services**
- **onsite or virtual wellness seminars that address common personal and work-related concerns and whole-person health**
- **EAP national wellness webcasts, which are available bimonthly, feature a calendar for live participation, and offer on-demand archives**
- **onsite, online, or virtual employee orientations that provide an overview of the EAP, discussion on accessing care, and a question-and-answer session**

- our Healthy Rewards® program that provides discounts on a wide range of complementary health care services and products
- online quarterly reporting
- follow-up services for the following:

- referrals to community resource programs including the following:
- Alcoholics Anonymous, Gamblers Anonymous, and Narcotics Anonymous
- Reach to Recovery (American Cancer Society)
- acquired immunodeficiency syndrome support groups
- local church-sponsored support groups
- sexual assault and recovery centers
- digital managing stress toolkit
- suicide prevention and awareness resources on
- EAP coverage page on myCigna for digital engagement, live chat, and self-service tools
- access to a page on our public website, www.cigna.com, specific to racial injustice and trauma (Better Together: Advancing the Race Dialogue)
- our behavioral health awareness series
- support for bereavement, divorce, domestic violence, eating disorders, exercise, and smoking cessation
- support before, during, and after a disaster, tragedy, or disruptive event through our Disaster Resource Center
- Management services include the following:

- unlimited telephonic assistance, coaching, and consultative support for managers and HR professionals, available 24 hours a day, 7 days a week, 365 days a year
- an EAP Resources for Managers and Organizations microsite
- management trainings via seminars, group discussions, and online resources
- management/mandatory referrals for significant job-performance concerns
- onsite or virtual orientations that provide a detailed overview of our overall EAP services, including management consultations and mandatory referrals as well as a question-and-answer session
- mandatory referrals for job jeopardy resulting from a positive drug screen or other corporate policy violation
- reporting on intervention and referral outcomes
- Organizational services include the following:

- critical incident stress management (CISM) that includes the following:

- **support that is available 24 hours a day, 7 days a week, 365 days a year**
- **a critical incident needs assessment**
- **an onsite response team (if determined to be the appropriate response)**
- **management/organizational recovery consultations**
- **critical incident diffusing/stress debriefing/education**
- **follow-up and subsequent recommendations, as needed**
- **EAP seminars and management trainings to complement wellness initiatives**
- **customized workshops**
- **online quarterly reporting that includes the following:**
- **an overview of services provided and utilization results**
- **the presenting problem and assessed problem profiles**
- **the type of referral**
- **the number of web presentations viewed**
- **the disposition of closed cases**
- **the distribution and frequency of sessions**
- **the number of unique employees utilizing face-to-face EAP services**
- **a comparison to book-of-business norms**
- **a communication program that includes the following:**
- **a proposed visibility plan**
- **an employee brochure with wallet cards**
- **introductory and electronic posters**
- **flyers and e-cardsmonthly health and wellness topics**
- **newsletter articles**

8) Provide a complete listing of EAP services provided to employees.

Response: **Employers and employees, along with their household members, have access to the following EAP and work/life services:**

- **problem assessment, resolution, and/or referral services**
- **unlimited, telephonic, 24/7 consultations with licensed clinicians**
- **access to text-therapy via Talkspace (as part of the visit per issue model)**
- **virtual counseling**
- **online authorizations and appointment scheduling**
- **find-a-provider appointment service search**
- **access to sessions per issue via MDLIVE (a Cigna affiliate)**
- **national network of over 130,000 EAP providers**
- **includes our behavioral fast access network**
- **subset of our behavioral health network for seamless referrals**

- **24/7 crisis triage assistance**
- **extensive work/life resources and referrals**
- **legal, financial, and identity theft consultation(s)**
- **online EAP and work/life tools and resources**
- **follow-up on referrals**
- **mindfulness, resiliency, and stress management tools**
- **Healthy Rewards® program**
- **online savings center**
- **orientations, seminars, and trainings (virtual, onsite)**
- **EAP national wellness webcasts with on-demand archives**
- **management consultation and referrals**
- **critical incident stress management (CISM)**
- **disaster response resources**
- **EAP Resources for Managers and Organizations microsite**
- **Coronavirus Resource Center**
- **Advancing the Race Dialogue microsite**
- **LGBTQ+ resources**
- **communications (e.g., posters, brochures)**
- **quarterly, monthly, and ad hoc reporting**
- **designated account management services**

Our EAP also offers optional buy-up services. Examples include onsite EAP services, geriatric case management, fitness-for-duty review, substance abuse provider evaluations, and lactation consultation services.

9) Provide a complete listing of all limitations and exclusions to the behavioral health program.

Response: **We facilitate health care provider network expertise for all behavioral health conditions. We have no exclusions or limitations within our national network.**

10) Provide a description of any outreach programs used to identify special needs groups (i.e. women's health, depression, anxiety, domestic violence and substance abuse, etc.)

Response: **Our Narcotics Therapy Management Program identifies members who are at high risk of misuse, fraud, and complications of opioid use. Subsequently, we reach out to those members with a higher probability of risk based on the results of our predictive model.**

We have developed predictive models to increase identification and engagement. These include a model that identifies members likely to go

out-of-network for a substance use service in the next six months. We base identification on a number of predictive factors, including out-of-network substance-use and mental-health claims, number of office visits, number of partial hospitalizations, and daily use of medication. We mail an educational flyer to identified members and follow-up with phone calls to increase reach, engagement, and in-network steerage.

We have also established predictive models that identify members ages 18–25 who are at high risk for readmission for a substance use or mental health disorder within six months of an acute inpatient admission. Our case management staff reach out to the identified members and provide education on available resources, in-network health care providers, case management programs, and the benefits of in-network health care.

Additional predictive models address various populations, including behavioral high-risk youth, individuals with autism at risk for inpatient and emergency room utilization, individuals with eating disorders at high risk, and individuals with alcohol use disorders with and without medical comorbidities.

We utilize machine learning and artificial intelligence (AI) models as part of our predictive models. Our machine learning and AI models leverage a comprehensive dataset including, but not limited to: behavioral health, medical, and pharmacy claims; labs; biometrics; demographics; social determinants of health indicators; and telephonic/digital interactions. We also utilize machine learning and AI as part of our 24-hour, on-demand digital coaching services offered via Headspace Care (formerly Ginger).

11) Where is your clinical staff located for behavioral health and EAP services?

Response: **All of our clinical operations staff, including personal guides, work virtually at home in a designated, secure workspace.**

12) Describe the types of case management programs included in your proposal.

Response: **One of our chief areas of investment is in our medical management program. We have developed our Health Matters Care Management Preferred model to better improve the health of our clients' employees and their family members while lowering overall health care costs for everyone. Our care management solution allows us to**
find members early and proactively and engage them in our programs;
personalize the experience to each member, because everyone's needs are different;
connect our members to the right resources for their diagnosis and personal situation;

help members find and use quality, cost-effective care; and approach our members consultatively to better understand their condition and treatment options. We get to know our members, and we stay connected with them throughout their journey to better health. In addition, we continue to invest in systems and infrastructure that allow our clinicians to effectively support our members' needs. We have created a blended set of assets, which will provide a more holistic, time-sensitive view of member information. This allows the delivery of an optimal engagement experience for our members by identifying, prioritizing, and aligning their most critical actionable items with the right expert resource at the right time. Other platform covered services include the ability to support alternate care delivery models to meet diverse client needs and a tighter integration with both internal and external business partners that allow for improved clinical outcomes as we manage our member needs more holistically.

Finally, as part of our goal to provide a consistent, consultative experience for our members no matter how they interact with us, our nurse case managers are also part of our One Guide team. They receive enhanced training and technological tools that equip them to offer even more personalized interactions and exceptional service to members on issues that extend beyond health concerns, such as plan benefits, claim issues, and provider questions.

13) Describe capabilities available through member website and mobile app. Please describe further any additional functionality available to employer as plan administrator.

Response: **Member Website/Mobile App**
Our member website, myCigna, will continue to provide an easy and convenient way for the City's members to manage their health and health-related finances. Members can download the free myCigna mobile app to access their personalized information whenever it is convenient for them. Members can access personalized myCigna features to do the following:

- **manage health information, such as health goals and incentives, on My Health Dashboard**
- **view and update personal health records (PHRs) with key biometric data, medical conditions, medications, allergies, surgeries, immunizations, and emergency contacts**
- **complete a health assessment and get recommendations based on the health assessment's health profile**
- **link to other interactive tools and learn about available Cigna programs**
- **locate doctors and review quality ratings and find out-of-pocket cost estimates for 17,000 medical procedures**

• search for behavioral providers and learn about the different types of care available
• get information on more than 8,000 topics on health conditions, medical tests and procedures, medications, and everyday health and wellness through Healthwise, an interactive library
• review coverage information
• view status of claims submitted in the past 24 months
• view EOBs, account balances, and transaction history
• view, print, send, or order a Cigna ID card
• refill prescription medications using our home delivery pharmacy
• compare drug price quotes, based on coverage, for specific pharmacies, including our home delivery pharmacy
• The new My Medications section of the myCigna® member website and mobile app gives members easy access to manage their prescription medications 24 hours a day, 7 days a week.
• get information on numerous medical and surgical procedures through a personalized report
• access the Healthy Rewards® alternative medicine program, which includes discounts for services such as acupuncture, chiropractic care, massage, cosmetic dentistry, laser vision correction, and hearing care
• sign up for reminders to take medication(s) and order refills through Cigna's medication coaching program (which also offers members who use our home delivery pharmacy reminders to check vital signs)
• receive their health care provider's address and contact information via email, text message, or vCard as well as WebMD medical alerts

Tools to Compare Cost and Quality

Using our Cost of Care estimator, members can compare cost and quality for providers in their area for specific procedures/conditions. The tool displays the results of the overall score for each facility by procedure. It also identifies Centers of Excellence when they achieve the three-star score for cost efficiency and patient outcomes. This tool empowers members with the information they need to help make the important decision of where to receive care.We have integrated our cost and quality transparency tools directly into doctor and hospital searches so every search returns cost and quality information. Cost estimates are available for more than 600 common medical procedures, which represent 80 percent of medical costs. Each year, our Cost of Care Estimator delivers estimates that are within 10 percent of the member's cost 90 percent of the time.Other tools include the following:

• Brighter Match - This feature guides members to the best health care providers to treat their needs through personalized recommendations, validated patient reviews, and fully integrated access to cost and quality

tools. This technology is based in data-driven algorithms that match the member with the highest-value provider in their area.

• Price a Medication Tool - This tool lets members browse and compare medication prices across dozens of pharmacies, including our home delivery pharmacy. They also have the ability to view and select from their medication history and preferred pharmacies for an easier search experience. Further, our Price a Medication Tool has enhanced alerts for when a medication is not covered or requires other direction.

Virtual Care

Members have access to virtual care through Cigna's expansive network of providers in addition to our nationally contracted partner, MDLIVE. Members can search for network providers in the provider directory on myCigna and contact their offices to make appointments, either in-person or virtually. Members can also directly access MDLIVE for virtual on-demand care or to schedule a virtual appointment through the myCigna website or app. Members are transitioned from myCigna onto the MDLIVE platform using an easy single-sign-on experience which does not require members to create and remember a second username and password. Once a visit is completed, claims are batched by MDLIVE nightly and sent to Cigna to be processed.Virtual care costs for exclusive virtual care providers (e.g., Talkspace, MDLIVE) are displayed on myCigna to deliver price transparency to our members. MDLIVE also displays member-specific cost information on their platform.

Client Website

To make your plan administration easier, our secure client resources website will continue to provide the City a single point of access to tools and services. The City will receive a unique user ID and password and will be able to do the following:

- **enter and maintain eligibility records for newly hired employees**
- **perform yearly open enrollment for plan members**
- **view and print booklets/certificates**
- **access standard suite of billing, pharmacy, and eligibility reporting**
- **view and print health care provider directories**
- **view employee claims**
- **download open enrollment/packet materials**
- **view and print ID cards**
- **access Consultative Analytics reporting**

With approval from the City, Cigna can grant brokers and consultants access to the website. There are no additional charges for our online services.

14) Describe any available benchmarking tools proposer can provide.

Response: **We use our book-of-business to create our normative database. We update norms regularly; they are available by plan coverage at the national level. We developed norms to track utilization patterns and plan design costs and are able to provide our book-of-business data for comparison purposes. Examples of the common comparisons made to our norms include the following:**

- **member cost sharing**
- **payments as a percentage of total paid**
- **major diagnostic categories as a percentage of total**
- **distribution of payments by service setting**
- **distribution of payments by type of health care provider**
- **payments by dollar range (percentage of claimants and percentage of dollars)**
- **average payment per unique claimant**
- **average pharmacy payment per member Benchmark-or normative-data is updated periodically each year based on changes that occur in the our membership and how that membership uses health care. Changes may include treatment plan compliance rates, demographic averages, site-of-care utilization rates and costs, and health advocacy engagement rates.**

15) For EAP Services, will employees have access to 24 hours crisis and intervention services?

Response: **Yes.**

16) Will you provide education and educational materials to employees regarding available behavioral health programs? If yes, please describe.

Response: **Yes. We provide the City with a variety of ready-to-use communication materials about its coverage. These may include presentations, printed or electronic flyers and brochures, newsletters, emails, posters, table tents, and the like, and they can vary depending on the plans offered. We typically do not send communications directly to employees but rather make them available to clients for distribution. The client service executive or account management team can assist in determining the best communications to use. In addition, the client service executive or account management team can provide or arrange for training or workshops on communication materials. Further, members may access myCigna for personalized plan information (e.g., plan descriptions, claims, forms, cost and quality tools, health assessment).**

17) Under what circumstances and how frequently are new mental/behavioral health network providers added to the network.

Response: **We proactively monitor the adequacy of the national network on an ongoing basis by combining eligibility data and current provider counts into a single tool, the network adequacy report, which we publish quarterly with detailed reporting at the metro and county area levels. We determine provider-to-member ratios according to access standards for each type of provider by geography. We use this report to identify areas where an opportunity exists to develop actions plans to enhance the network through contracting activities.**

To ensure our nationwide network meets the needs of the members we serve, our provider relations department also utilizes geo-accessibility analyses, which measure the percentage of members with access to providers within established access standards (e.g., distance and time). These analyses allow the provider relations staff to identify specific geographic areas where there may be a need for network development to address network access gaps.

Further, our health care provider management and referral system ensures that each geographic area our network consists of facilities and providers offering behavioral health services and specialties. The system can identify providers and facilities by location, services, and contracted providers with admitting privileges.

To further support member participation, we also oversee recruitment activities to ensure appropriate network access and adequacy of needed specialized services by

- **responding to sales and account management requests;**
- **monitoring out-of-network and ad hoc utilization patterns;**
- **recruiting specialties (e.g., autism, EAP services, providers specializing in racial/ethnic concerns);**
- **maintaining the network to ensure composition, accessibility, and accuracy; and**
- **emphasize website directory maintenance and expansion.**

18) How would transition of care be handled for members currently under care with a provider that is not in your existing network.

Response: **Transition of Care (TOC) does not apply to someone who has been an enrolled Cigna member during the previous contract period; however, if a member or spouse/partner/dependent of an existing Cigna member is first added to a Cigna plan at the time of contract renewal, that person would be a new member for that plan year and would be eligible for TOC consideration.**

Cigna will make every effort to manage the member's transition of care (TOC) from a nonparticipating health care provider to avoid a disruption of services that may impact the member's health status. There are no additional fees for these services.

Members must apply in writing for in-network-level TOC within 30 days of enrollment in a Cigna-administered health plan (unless the applicable state mandates a longer period). If Cigna approves coverage, a member may continue to receive services from that doctor, hospital, or other provider for a specified period with covered services paid at the in-network coverage level. Members may contact a One Guide personal guide for assistance with completing the TOC application. The personal guide records the information the member provides and submits the application on his or her behalf.

Review Process

As a first step in the review process, the TOC request is examined to see whether it meets certain criteria. The following are examples of conditions that may qualify for TOC coverage:

- **second or third trimester of pregnancy as of the start date of coverage**
- **newly diagnosed or relapsed cancer (chemotherapy, radiation therapy, or reconstruction)**
- **transplant candidates, unstable recipients, or recipients who need ongoing care because of transplant-related complications**
- **acute conditions like heart attacks, strokes, or unstable chronic conditions in active treatment**
- **recent major surgeries still in the follow-up period (generally six to eight weeks)**
- **hospital confinement on the plan start date (for plans that do not have extension of coverage provisions)**
- **trauma**
- **nonparticipating health care facility services for inpatient care (maternity or hospice care associated with a TOC request when nonparticipating doctor, hospital, or other provider services are approved for TOC and the doctor, hospital, or other provider does not have privileges at a participating health care facility)**

Broadly speaking, conditions generally approved for TOC include those related to obstetrics, oncology, organ transplants, major surgery, and MHSUD. Other conditions, such as terminal illness, scheduled surgeries, and chronic illness, may be considered and approved for TOC based on the specific member's circumstances.

If the TOC request meets the inclusion criteria, Cigna may complete a medical necessity review upon receipt of the clinical information from the member or provider and may make a determination about coverage of

the above services.Unless otherwise required by applicable state mandates, which always take precedence, TOC approvals apply to an appropriate period following the member's start date (e.g., 30, 60, or 90 days) or until the member completes care or transitions to a participating doctor, hospital, or other provider or exceeds coverage limitations, whichever occurs first. Approvals do not generally exceed 90 days.

19) How would transition of care be handled if a provider is terminated during the course of treatment.

Response: **When an in-network health care provider leaves the Cigna network, Cigna makes every effort to manage the member's continuity of care (COC) to avoid a disruption of services that may impact the member's health status. There are no additional fees for these services. Changes to Cigna's COC processes have been implemented where needed to address requirements of the No Surprises Act.**

Members must apply in writing for in-network-level COC within 30 days of the provider's change in status (unless the applicable state mandates a longer period). If Cigna approves coverage, a member may continue to receive services from that doctor, hospital, or other provider for a specified period with covered services paid at the in-network coverage level. Members may contact a One Guide personal guide for assistance with completing the COC application. The personal guide records the information the member provides and submits the application on his or her behalf.

Review Process

As a first step in the review process, the COC request is examined to see whether it meets certain criteria. The following are examples of conditions that may qualify for COC coverage:

- **second or third trimester of pregnancy as of the start date of coverage**
- **newly diagnosed or relapsed cancer (chemotherapy, radiation therapy, or reconstruction)**
- **transplant candidates, unstable recipients, or recipients who need ongoing care because of transplant-related complications**
- **acute conditions like heart attacks, strokes, or unstable chronic conditions in active treatment**
- **recent major surgeries still in the follow-up period (generally six to eight weeks)**
- **hospital confinement on the plan start date (for plans that do not have extension of coverage provisions)**
- **trauma**
- **nonparticipating health care facility services for inpatient care (maternity or hospice care associated with a COC request when nonparticipating doctor, hospital, or other provider services are approved**

for COC and the doctor, hospital, or other provider does not have privileges at a participating health care facility)
If the COC request meets the inclusion criteria, Cigna may complete a medical necessity review upon receipt of the clinical information from the member or provider and may make a determination about coverage of the above services. Unless otherwise required by applicable state mandates, which always take precedence, COC approvals apply to an appropriate period following the date of the current provider's change in network status; until the member completes care or transitions to a participating doctor, hospital, or other provider; or exceeds coverage limitations, whichever occurs first. Approvals do not generally exceed 90 days.

20) How many visits are included under the EAP Program?

Response: **We are proposing to continue the existing 1-3 session model. Please refer to the Renewal Letter for additional details.**

21) Describe the virtual visit (Telemedicine) program included in your plan.

Response: **Virtual care brings employers a digital-first care solution employees are using like never before. Our virtual solutions complement each other to deliver affordable, convenient care and an integrated customer service and technology platform for members, and lower total medical costs for our clients. The City will continue to benefit from lower absenteeism, higher productivity, and the convenience of integrated administrative services. Our virtual care portfolio includes a wide breath of services offered through our network health care providers and through our partnership with MDLIVE at no additional administrative fee. Members also have access to virtual and digital care services through in-network behavioral health care providers and our National partnerships with Talkspace, Headspace Care (formerly Ginger), Meru Health, Brightline, and more.Virtual care through MDLIVE is standardly included in medical and behavioral plans at no additional cost to the client or member. Services include:**

- **Urgent Care - Members can choose the time and day that works best for them with urgent care available 24 hours a day, 7 days a week, 365 days a year. Effective in late 2024, members also have the option to quickly access quality care when a phone or video interaction isn't necessary through asynchronous care.**
  Urgent care with MDLIVE on average yields 91% savings compared to ER visits. It is also 79% less costly than urgent care center visits and 62% less costly than PCP visits.

- **Primary Care - Members can connect to providers virtually for preventive wellness screenings and routine care with chronic condition management and digital health coaching. In 2023, chronic condition management and digital health coaching were made available for hypertension, pre-diabetes, and weight management. These services will expand throughout 2024 to include other common conditions.**

- **Specialty Care (Dermatology) - Dermatology visits can be initiated anytime, anywhere; members can message with dermatologists by sharing photos of affected areas and describing symptoms and will receive treatment plans and prescriptions (if appropriate) usually within 24 hours.**

- **Behavioral Care – For behavioral health concerns, members can access therapy and medication management appointments, in addition to other care modalities, such as digital cognitive behavioral therapy and on-demand coaching.**

22) Do you provide access for employees to download a smartphone application to their electronic devices? What services are provided through this application?

Response: Yes. **We connect members 24 hours a day, 7 days a week, 365 days a year with access to myCigna to quickly provide the information they need to manage their health—anytime, anywhere. We offer two secure ways for members to access myCigna when they are on the go:**
• myCigna Mobile App - a free, safe, and secure native application for iOS (Apple), Android, and Kindle mobile devices that provides members with access to personalized health care information
• myCigna Mobile Web - myCigna operates on a response web design and is accessible via any mobile device with an internet browser—replicating all the information viewable on the desktop available 24 hours a day, 7 days a week, 365 days a year, these features offer access anytime, anywhere from mobile phones and tablets:
• Virtual Care - access a nationwide network of board-certified doctors for minor/acute conditions through secure video and phone capabilities and receive a written nonnarcotic prescription by a doctor, if warranted (mobile and web only) (Members can also access virtual care for behavioral needs.)
• Health Assessment - access a health assessment tool from the myCigna mobile dashboard (Members who complete the self-guided questionnaire will receive an email confirmation as well as a wellness

score and tips to improve their overall health.)
- **Provider Directory - search for a doctor, pharmacy, or health care facility from our national network and compare quality-of-care ratings and costs (Mobile app is GPS enabled.)**
- **Therapist Match - The therapist match feature will enable members enrolled in a behavioral health plan to find the right therapist the first time, with a more personalized experience. When members begin their search, they are guided through a set of questions developed based on extensive research, testing, and reviews by diversity, clinical and behavioral teams, that will match them to the right therapist.**
- **Procedure Search - search hundreds of common medical and dental procedures and compare costs for doctors, and facilities and make choices based on personalized costs. (We do the math—including the member's deductible, coinsurance, and health care accounts .**
- **ID Cards - quickly view, request, and print ID cards (front and back) for the entire family on the mobile web and easily view, save to Apple Wallet, print (iOS devices only), email, or scan with the mobile app**
- **Account Balances - review plan deductibles and maximums**
- **Incentives – our Cigna Healthcare℠ Well-Being Solution - view incentive information (e.g., goal activity and rewards)**
- **Health Wallet - organize and manage health information, store biometric values (e.g., cholesterol levels, blood pressure), save contact information, and build a personal contact list of doctors, hospitals, pharmacies, ERs, and other providers and facilities (mobile app only)**
- **Claims - view EOBs, search recent and past claims and bookmark/group claims for easy reference**
- **Submit Claim - members can submit in-and out-of-network claims using the online claim form. (mobile web only)**
- **Coverage - view plan coverage and approval guidelines**
- **Home Delivery Pharmacy - refill medications, check order history, and update billing and shipping preferences**
- **Drug Search - compare retail pharmacies nationwide with our home delivery pharmacy, Express Scripts Pharmacy (a Cigna company); receive pricing based on specific coverage, including deductibles, copays, coinsurance, and out-of-pocket limits (members receive lower-cost options for medications); find the closest pharmacy (mobile app uses GPS); and speed dial our home delivery pharmacy (mobile app)**
- **Languages - find health information in both English and Spanish**
- **Shared Access - delegate access to an eligible dependent on the primary member's plan**

We use the latest security technology and protocols (including multifactor authentication) in mobile applications to protect members' personal health information while they are both on- and offline.

23) What cyber security protocols do you have in place to safeguard and protect

patient information from a data breach?

Response: **Cigna will continue to maintain proper security to safeguard client and member information and to protect other sensitive information. We design security solutions using the following framework:**
• Identification and Authentication - confirms identity
• Access Control - prevents unauthorized use
• Confidentiality - prevents unauthorized disclosure
• Data Integrity - prevents unauthorized modification
• Data Availability - ensures availability of data
• Auditing - maintains evidence of unauthorized use
• Nonrepudiation - provides evidence of origin and receipt
An extensive security policy for our employees and contractors covers areas such as
• computing resource use;
• information handling;
• physical protection;
• business continuity planning; and
• information protection awareness and training.
Security standards specify how our hardware and software should be configured, and a privacy policy governs the handling and use of member information. Dedicated, professional security staff develop safeguards and help ensure that standards and policies are followed. We have processes in place to investigate and contain computer viruses and internal security incidents and to detect any unauthorized access to our computer network.
A three-level system maintains physical security at our facilities by authorizing appropriate access into our facilities, properly identifying each person, and defining the working areas to which people have access.
If a breach of data were to occur, Cigna's incident response team consisting of key business personnel, including the privacy office and Cigna Information Protection, immediately assembles to thoroughly investigate, mitigate, and resolve the incident. The client manager will notify the client/the Fund group via phone or email as soon as possible to apprise it of the situation.
Cigna will perform a fact-based risk assessment, considering the following (at a minimum): (i) the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made; (iii) whether the PHI was actually acquired or viewed; and (iv) the extent to which the risk to the PHI has been mitigated, as required by the Health Information Technology for Economic and Clinical Health Act (HITECH), to determine the probability of whether or not the PHI is compromised. Cigna will continue to provide The City with the results of its risk assessment and will make a recommendation to The City about

whether notification is required pursuant to 45 CFR §164.404–408. Cigna will issue such notices (to members, to the Department of Health and Human Services[HHS], and to the media) as The City is required to issue pursuant to and in accordance with the requirements of 45 CFR §164.404–408. Cigna will pay the costs of issuing notices required by law and other remediation and mitigation, which, in Cigna's discretion, are appropriate and necessary to address the breach. Cigna will not be required to issue notifications not mandated by law. Depending upon the type of incident and information placed at risk, Cigna may offer free credit monitoring services to the member(s) affected for up to two years. Cigna maintains a log of breaches and will provide any pertinent portion of the log to the client annually in support of The City's regulatory reporting obligations. Cigna will notify the client of a breach without unreasonable delay. This notification will include the following, to the extent known:

• the names of the members whose PHI was involved in the breach
• the circumstances surrounding the breach
• the date of the breach and its discovery
• the information breached
• the steps impacted members should take to protect themselves
• the steps Cigna is taking to investigate the breach, mitigate losses, and protect against future breaches
• a contact person who can provide additional information about the breach

Cigna's account client/relationship manager will apprise the Fund/client as soon as possible when a problem is identified. Plans to notify the affected members will also be communicated. If Cigna's business associate or third-party vendor (TPV) notifies us of an issue, a Cigna incident team is established, and Cigna will work with the business associate as needed to ensure that the issue is investigated, mitigated, and resolved. Once a breach is confirmed, the notification process begins as soon as reasonably possible. Member communication is an integral part of Cigna's incident handling process. The incident team is the focal point for crisis communications and activities across the enterprise to ensure consistency, efficiency and effectiveness. Additionally, Cigna maintains a comprehensive cyber-risks/data, breach/privacy liability insurance program. This program provides coverage for data breaches, unauthorized access to or use of computer systems (including personal handheld devices and laptops), loss or disclosure of confidential or personal information, third-party liability arising out of any loss data or information that is deemed confidential by any applicable law, and technology E&O.

24) Please identify the account representative that will be assigned to the City of Coral Gables. Attach a brief resume for this individual

Response: **Dina D'Angelo – Senior Client Manager**

As a Senior Client Manager, Dina is responsible for renewal of accounts, service team supervision, renewal strategy discussions with clients and brokers, financial and claims experience reporting.

Dina D'Angelo joined Cigna in April 2006. She has over 25 years of experience in the healthcare industry. She has held positions in Provider Relations, Contracting and Client Management with Tenet, HCA, United and now Cigna. Her book of business consists of middle market municipality business in the State of Florida.

Dina holds an insurance license in the State of Florida and a Bachelor of Science Degree in Business.

25) Please identify all other key personnel that will be assigned to the City of Coral Gables.

Response:
Dina D'Angelo – Senior Client Manager
Joyce Lau – Client Account Manager
John Kura – Client Service Executive
Nicole Watson – Engagement Consultant
Mary Terry-Clines – Implementation Manager

26) Please confirm that a representative will be available on a Quarterly basis to meet with employees to discuss benefit and claim related issues.

Response: **Confirmed**.

27) Are there any services unique to your company that you feel should be highlighted to the City of Coral Gables?

Response: **We are confident in our ability to service the needs of the City. We have been offering health plans to America's local governments and educational institutions for more than 200 years, and through our specialized government and education team, we currently serve more than 1.7 million members. We have strong, deep connections in Florida and provide coverage to a total of 210 government and education clients and 520,607 employees. Our specialized team will continue to help The City design cost-effective, personalized coverage solutions that connect employees to the programs, services, and health care providers they need to adopt healthier lifestyles.**

We accomplish this through
- **personalized health and wellness solutions;**
- **customized employee engagement tools and resources;**

• easy, helpful, and convenient specialized customer service and a specialized, highly trained multidisciplinary team;
• integrated solutions to support employees' total health and well-being; and
• a focus on health equity.
We are committed to designing customized health and wellness solutions that are relevant and effective for each local government, school district, and higher education institution we serve.

28) Are there promotional materials available prior to enrollment to educate employees regarding plan benefits and/or carrier changes? Are there materials or web-based initiatives available throughout the year to encourage better use of the program? Are there additional costs associated with these materials?

Response: **Yes. Communication materials will continue to be available pre and post enrollment, based on the City's plan offerings and needs, and are a standard part of our account implementation process at no additional cost.**
Preenrollment materials may include the following:
- **an enrollment application**
- **a Certificate of Coverage**
- **HIPAA special enrollment rules**
- **medical, pharmacy, dental, and/or vision brochures**
- **information on additional resources and services (e.g., health information line, health assessments, cost and quality tools)**

Post-enrollment materials may include the following:
- **a myCigna flyer**
- **Cigna Pharmacy brochures and order forms**
- **other consumer health engagement brochures and materials (depending on coverage)**
- **ID cards (mailed separately)**
  Cigna delivers standard printed materials to the client approximately 10–15 business days after placing the order.

An enrollment kit that includes descriptive brochures, a client-specific coverage summary, and an enrollment form is available for open enrollment in both print and digital formats.
We will continue to work with the City to create an effective communication program to meet three key objectives:
- **enhance employee appreciation for the provided coverage package**
- **streamline plan administration by educating employees on procedures and policies**

- **educate and motivate employees to use the cost and quality tools and features of their plan to help reduce coverage costs**

29) Does your company have representatives that employees may call for benefit related questions? Are there representatives available to assist with health related questions or concerns (i.e. nurse help line).

Response: **Yes. Members can call our preenrollment team 24 hours a day, 7 days a week, 365 days a year. The line remains open year-round so new hires and current members can receive support beyond the open enrollment period. In addition, our specialized Smart Support service team, who have deep knowledge of plan benefits, will continue to provide support to your employees and their families.**

Our health information line, available to all medical members, is staffed by RNs who have a nursing license in at least one state and is available 24 hours a day, 7 days a week, 365 days a year. It is provided at no additional cost and includes general health information, level-of-care action recommendations, follow-up outreach as appropriate, chat with a nurse functionality an audio library with hundreds of health-related subjects, guidance for members to network doctors and facilities, and handling of after-hours precertification requests from health care providers.The health information line's data system seamlessly integrates with our health advocacy and medical management programs, allowing nurses to view the Cigna programs available to members and refer them appropriately. These programs and services include internet resources, medical case management, coaching programs, and behavioral/EAP services.

30) What is the usual timeframe for a member services' representative to call back a member on an issue?

Response:**Advanced tools and systems, coupled with our highly skilled service professionals, drive the goal of resolving 90 percent of client and member inquiries during the first call. Our 2023 results show indicate that we achieved 94.9% first call resolution and 98.7percent of calls closed in 5 days and 99.5 percent closed in 10 business days.**

31) What is the procedure when a member's service call is received outside of proposer's working hours?

Response: **Our customer service team offers will continue to support to your employees and their families 24 hours a day, 7 days a week, 365 days a year. The City's membership will be serviced by our Smart Support service team, who have deep knowledge of plan benefits, located**

throughout the US, from 8:00 a.m. to 8:00 p.m. (EST). After hours and weekend/holiday support is provided by our extended service team.

32) Are physicians, clinics and/or hospitals rewarded for improving quality performance? If yes, describe in details, incentives, rewards, and shared savings.

Response: **Yes. Our value-based care solution, Cigna Collaborative Care (CCC), is built on over 20 years of partnering with providers and hospitals to reduce costs and improve health outcomes. Our hands-on approach helps us meet health care providers at their current level of performance and take them where they need to be—delivering care built on evidence-based standards that improve quality, cost, and patient satisfaction. Many competitors require clients to purchase a value-based arrangement; however, we have proactively embedded our arrangement within our national networks for decades.**

Currently, we have value-based arrangements with more than 230 provider groups, 890 hospital facilities, and 100 specialists. The solutions include:

- **Primary Care through Accountable Care Programs - Our first collaborative value-based care arrangements focused on large doctor groups and were built on the Patient-Centered Medical HomeTM (PCMHTM) and Accountable Care Organization (ACO) models.[1] We continue to expand our models to fit the readiness and resources of our network providers. Our program delivers the tools and services that we know providers need to be successful.**
  - **Actionable Insights - With tools like iCollaborate, we provide actionable data to ACO program provider groups, so they can proactively work with their patients to coordinate care and meet clinical needs. We don't just share data; we provide more data than our competition and translate it to help them understand which specific actions to take based on the information we share. Groups can clearly see which patients have a current or recent hospitalization, have health risks and gaps, are compliant with their medication(s), and are participating (or have participated) in health coaching and case management programs.**
  - **Clinical Support - We provide local clinical collaboration teams to support our value-based care relationships, including market medical executives who meet regularly with each group to review results and work with groups to identify actions to improve quality, affordability, and the health care experience. We hold well-attended quarterly learning collaborative meetings, three virtually and one in person, with every participating program provider group.**
  - **Integrated Care - The solution leverages clinical programs and patient data to engage patients with additional clinical services (if needed). Our embedded care coordinator model is unique in the industry; it includes clinicians, employed by and seated in the**

provider practice, who serve as valuable resources in coordinating patient needs, identifying opportunities to improve performance, and reaching out to the patients who need this contact most. Our dedicated, experienced case managers are also available to help with coordination between the provider group and every other Cigna Healthcare-offered service.

- **Aligned Pharmacist Program - This program aligns a Cigna Healthcare pharmacist to a point of contact within the collaborative care provider group when the group opts into the program. The two work together to identify actionable pharmacy opportunities based on shared information and clinical data, providing our members with ongoing, consistent, and personalized pharmacy support. (Include this bullet if quoting medical and pharmacy.)**
- **Specialists - These value-based arrangements include multiple specialist groups (orthopedics, cardiology, gastroenterology, nephrology, and OB/GYN).**
- **Hospitals - Many of our members with high-cost conditions or complex needs receive treatment in a hospital. Our initiatives with hospital facilities are value-based arrangements that promote quality, safety, and efficiency.**

We continue to expand CCC both in breadth and scope. Specifically, we advanced our solution to reward providers for social determinants of health screenings, referrals to community support organizations, and action plans to eliminate disparities in their patient population. We are the only carrier to address these needs for the non-Medicare population in our value-based arrangements.

All of the above results in providers:

- **Performing 52% better-than-market for inpatient readmissions.**
- **Performing 75% better-than-market at helping patients avoid unnecessary visits to the ER.**
- **Meeting or exceeding quality index benchmarks by 72% when compared to the market.**

(1) Patient-Centered Medical HomeTM (PCMHTM) is a trademark of the National Committee for Quality Assurance (NCQA).

33) Do you have a network management/provider services department that assists with provider issues?

Response: **Yes. We align a designated provider relations specialist to all contracted providers, which is a differentiator in the industry, so**

that providers can focus on the health of their patients.
The provider relations specialist supports providers through our end-to-end service experience across onboarding, network and provider data management, patient care coordination, claims and reimbursement, service and support, and relationship management.
Some specific activities include the following:

- **implementing National Committee for Quality Assurance (NCQA) policies**
- **facilitating EFT administration**
- **coordinating internal activities**
- **maintaining and managing electronic data**
- **coordinating outreach and communication**
- **promoting two-way communications and helping to resolve issues**
- **providing ongoing policies and procedures training**
- **evaluating provider performance**

As a result of our support at each point of the provider cycle, we build trusted relationships with providers who positively influence patient behaviors for better health outcomes.

34) Does proposer have member service representatives with multi-lingual capabilities? (Spanish, Creole, other, please describe)

Response:
Yes. When a member calls One Guide and indicates a preference for Spanish, our natural language automated phone system routes the call to a bilingual One Guide frontline service personal guide who is able to provide Spanish-language assistance. If a bilingual personal guide is unavailable, or when a member needs help in another language, we set up a conference call with an interpreter through LanguageLine Solutions, a nationally recognized certified foreign language interpretation service that supports more than 240 languages.

35) How does proposer's system identify potential COB (coordination of benefits) claim situations and maintain COB information on file?

Response: **We initiate COB action on claims for which a potential of additional group health coverage exists. If we are looking into the potential of other coverage, we do the following:**

- **investigate for other insurance postpayment**
- **deny at 90 days if we do not receive the needed information**

The standard for handling claims in known COB situations is to deny the claim at 90 days when we cannot complete the investigation satisfactorily. This means that when our eligibility system or the claim submission shows other insurance and we did not receive the other carrier's EOB or payment with the claim, the claim will be pended and a

message on the Cigna EOB will request updated COB information. In absence of a response, the system sends follow-up requests to the member at 30 and 60 days. If we do not receive a response at 90 days, we deny the claim.The nonstandard benefit is to pay the claim at 90 days. We investigate yearly for other health insurance. Throughout the year, we also use information on claim forms or other correspondence to update COB information.

36) Are the member grievances/appeals tracked and reported? If yes, are you able to provide a report capturing the number and types of grievances/appeals received?

Response: **Yes. Client-specific volume reporting is available quarterly, semiannually, or annually to determine decisions (separated by denial reason), root causes, and overturn and upheld rates. The account team's client service executive is responsible for running client-specific reports, exclusive of requests for PHI. The reporting does not include PHI. If the City has a business need to receive reports that include PHI, we will work together to review the need and make related arrangements as appropriate. Reports with PHI information and other ad hoc appeals reporting may include additional fees.**
Although no reporting is available to track the status of active appeals, we can give the status of a specific appeal or grievance to the client, if the member consents. With the member on the phone, a client may be included in a conversation about an appeal.

37) Describe proposer's formal grievance procedure, including response time?

Response: **Personal guides can often resolve issues for members. If they cannot, members can initiate an internal appeals process by phone or in writing up to 180 days from the date of last determination, or a shorter period if specified by the plan. The City may allow more than the Cigna standard of 180 days for filing appeals, but never fewer (per ERISA guidelines). Providers must initiate appeal requests in writing. Cigna offers a single-level internal process that addresses appeals concerning initial medical necessity determinations and coverage determinations. The process meets National Committee for Quality Assurance (NCQA), ERISA, URAC, and/or state regulatory requirements as well as our own internal empowerment program guidelines. Processes are in place to meet the Affordable Care Act (ACA) requirements. Cigna may change this process as needed to meet any additional state requirements.**
After receiving the appeal, we follow the mandated levels and timings required by the jurisdictional state. This includes external review offerings. Reviewers making appeal determinations were not involved in

the original decision, nor were their managers. A provider who is not a doctor (e.g., pharmacist, nurse) may make approval decisions on medical necessity appeals, but only doctors can make denial decisions. Nonclinical staff can resolve administrative appeals.We verbally communicate expedited-appeal decisions within 72 hours of receipt of the appeal and follow up in writing within state-mandated time frames. We communicate denials or overturns in writing. For claim overturns, we will issue an explanation of payment (EOP)/EOB within 15 calendar days of the decision (or the state-mandated time frame).An external review of medical necessity decisions by an independent review organization may be available.

Cigna Healthcare's approach to network strategy is unique — we realize the importance of discounts, but intentionally couple deep discounts with extensive care. From our large, national network and collaborative health care provider arrangements, we manage your member's care needs for a better overall total medical cost outcome. We can also offer flexibility in these network solutions: we give you the opportunity to choose the level of affordability and choice that meets the needs of your company's bottom line, and that of your employees, without compromising on the quality and cost everyone expects.

National Network - Our Open Access Plus (OAP) plan

Open Access Plus (OAP) plans will continue to provide the City's members with choice and convenience, including direct access to our broad, national health care provider network. Members have the option to choose PCPs to serve as their personal doctors and help coordinate health needs. Members can access care in- or out-of-network without a referral. Certain services and procedures may still require providers to obtain prior authorization from Cigna.

Value for Members

As with other Cigna plans, OAP offers the following:

- nationwide toll-free customer service
- no copays for immunizations and prenatal care
- emergency care covered 24 hours a day from any emergency facility
- access to any provider in- or out-of-network
- higher coverage levels when care is received within the OAP network
- an extensive, nationwide network of primary and specialty care doctors, hospitals, and other providers/facilities
- a variety of health advocacy programs designed to engage members across the health care continuum to ensure they receive appropriate support for their unique, individual needs while improving health and lowering cost

Our Open Access Plus (OAP) plan offers the City an extensive network of 1.5 million primary and specialty care doctors and 19,000 facilities. We are ranked the number one carrier for the breadth of our network over our competitors.

Value-Based Arrangements

Our value-based care solution, Cigna Collaborative Care (CCC), is built on over 20 years of partnering with providers and hospitals to reduce costs and improve health outcomes. Our hands-on approach helps us meet health care providers at their current level of performance and take them where they need to be—delivering care built on evidence-based standards that improve quality, cost, and patient satisfaction. Many competitors require clients to purchase a value-based arrangement; however, we have proactively embedded our arrangement within our national networks for decades.

Our current CCC programs include innovative solutions across the following provider types:

- **Primary Care through Accountable Care Programs** - Our first collaborative value-based care arrangements focused on large doctor groups and were built on the Patient-Centered Medical Home™ (PCMH™) and Accountable Care Organization (ACO) models.[1] We continue to expand our models to fit the readiness and resources of our network providers. Our program delivers the tools and services that we know providers need to be successful.
- **Actionable Insights** - With tools like iCollaborate, we provide actionable data to Accountable Care program provider groups so they can proactively work with their patients to coordinate care and meet clinical needs. We don't just share data; we provide more data than our competition and translate it to help them understand which specific actions to take based on the information we share. Groups can clearly see which patients have a current or recent hospitalization, have health risks and gaps, are compliant with their medication(s), and are participating (or have participated) in health coaching and case management programs.
- **Clinical Support** - We provide local clinical collaboration teams to support our collaborative care relationships, including market medical executives who meet regularly with each group to review results and work with groups to identify actions to improve quality, affordability, and the health care experience. We hold well-attended quarterly learning collaborative meetings, three virtually and one in person, with every participating program provider group.
- **Integrated Care** - The solution leverages clinical programs and patient data to engage patients with additional clinical services (if needed). Our embedded care coordinator model is unique in the industry; it includes clinicians, employed by and seated in the provider practice, who serve as a valuable resource in coordinating patient needs, identifying opportunities to improve performance, and reaching out to the patients who need it most. Our dedicated, experienced case managers are also available to help with coordination between the provider group and every other Cigna Healthcare-offered service.
- **Aligned Pharmacist Program** - This program aligns a Cigna Healthcare pharmacist to a point of contact within the collaborative care provider group when the group opts into the program. The two work together to identify actionable pharmacy opportunities based on shared information and clinical data, providing our members with ongoing, consistent, and personalized pharmacy support.

- **Specialists** - These value-based arrangements include multiple specialist groups (orthopedics, cardiology, gastroenterology, nephrology, and obstetrics/gynecology), which account for the majority of medical costs each year.
- **Hospitals** - Many of our members with high-cost conditions or complex needs receive treatment in a hospital. Our initiatives with hospital facilities are value-based arrangements that promote quality, safety, and efficiency.

We continue to expand CCC both in breadth and scope. Specifically, we advanced our solution to reward providers for social determinants of health screenings, referrals to community support organizations, and action plans to eliminate disparities in their patient population. Cigna is the only carrier to address these needs for the non-Medicare population in our value-based arrangements.

Currently, we have value-based arrangements with more than 231 provider groups across 34 states, 820 hospital facilities, and 120 specialists. We have the largest number of ACO partnerships across major carriers and we continue to grow.

Our goals for value-based initiatives include the following:

- **Accountable Care Program** - contract with approximately 271 arrangements by the end of 2025.
- **Hospital Program** - contract with more than 612 hospital initiatives by the end of 2025.
- **Specialist Programs (Including Episodes of Care)** - contract with more than 115 programs by the end of 2025.

Virtual Care Ecosystem

Virtual care brings employers a digital-first care solution employees are using like never before. Our virtual solutions complement each other to deliver affordable, convenient care and an integrated customer service and technology platform for members, and lower total medical costs for our clients. The City will continue to benefit from lower absenteeism, higher productivity, and the convenience of integrated administrative services.

Our virtual care portfolio includes a wide breath of services offered through our network health care providers and through our partnership with MDLIVE at no additional administrative fee. Members also have access to virtual and digital care services through in-network behavioral health care providers and our national partnerships with Talkspace, Headspace Care (formerly Ginger), Meru Health, Brightline, and more.

Virtual care through MDLIVE is standardly included in medical and behavioral plans at no additional cost to the client or member. Services include:

- **Urgent Care -** Members can choose the time and day that works best for them with urgent care available 24 hours a day, 7 days a week, 365 days a year. Effective in late 2024, members also have the option to quickly access quality care when a phone or video interaction isn't necessary through asynchronous care. Urgent care with MDLIVE on average yields 91% savings compared to ER visits. It is also 79% less costly than urgent care center visits and 62% less costly than PCP visits.
- **Primary Care -** Members can connect to providers virtually for preventive wellness screenings and routine care with chronic condition management and digital health coaching. As of 2023, chronic condition management and digital health coaching are available for hypertension, pre-diabetes, and weight management. These services will expand throughout 2024 to include other common conditions.
- **Specialty Care (Dermatology) -** Dermatology visits can be initiated anytime, anywhere; members can message with dermatologists by sharing photos of affected areas and describing symptoms and will receive treatment plans and prescriptions (if appropriate) usually within 24 hours.
- **Behavioral Care -** For behavioral health concerns, members can access therapy and medication management appointments, in addition to other care modalities, such as digital cognitive behavioral therapy and on-demand coaching.

Smart Support Program

A specialized customer service team, located throughout the US, will continue to provide support for the City's employees. This team is exclusively designed to help local government and education members balance a healthy lifestyle with health care costs.
As part of Cigna's Smart Support Program, employees will experience the following:

- **Dedicated Customer Service** - Our dedicated customer service team is available Monday through Friday, 8:00 a.m. to 8:00 p.m. (EST). Members calling to speak with someone on the dedicated team outside of these standard hours will reach a live customer service advocate (CSA) who can assist them. These CSAs have access to the same information and plan details so they can provide seamless support to members at any time of the day or night.
- **Dedicated Support through My Personal Champion® Program** - Our team of service professionals also includes personal champions. These individuals serve as a single point of contact for employees who need specialized support during periods of complex medical care that may result in significant administrative, social, or financial issues. Employees are identified and referred for this level of support by CSAs, case managers, client service executives, and clients or through claims and utilization data models.
- **Shorter Average Wait Times** - With a 60-second average speed of answer (ASA), employees will experience faster access to customer service.
- **Enhanced Communications** - Our specialized team includes a media specialist who monitors social media channels for questions and comments from employees. Our media specialist will promptly follow up on the same social media channel or through an appropriate private channel. Our team also customizes their communication approach based on the specific needs and preferences of each member.
- **More Options** - Employees have the ability to bypass the standard interactive voice response process and talk with a live service representative immediately after entering their Cigna ID.

In addition, the City members can continue to call our preenrollment team 24 hours a day, 7 days a week, 365 days a year. The line remains open year-round so new hires and current members can receive support beyond the open enrollment period.

Health Information Line

The health information line provides convenient, toll-free access to medical information and assistance at any time of the day or night. The information and support that the health information line supplies empowers members to take a more active role in their own health care.
This complimentary health information line service includes the following features:

- general health information about a variety of topics, including preventive care, illness and condition definitions, diagnostic tools, and surgical procedures
- level-of-care action recommendations (e.g., ER, urgent care, convenience care, doctor's office, virtual care, home/self-care)
- follow-up outreach (when appropriate)
- an audio library, which contains hundreds of health-related subjects

- guidance to network doctors and facilities including steerage to high-performing providers (e.g. Cigna Care Designated–providers)
- integration with Cigna's health advocacy programs and services

Nurses consult current, unbiased medical resources to answer member inquiries about health-related issues by phone. Nurses are licensed as RNs in at least one state.

Our health information line also provides LanguageLine Solutions services to our non-English-speaking members. This phone-based language service, capable of interpreting more than 240 languages, helps our nurses communicate with members for whom English is not their primary language. When a non-English-speaking member calls, the nurse contacts the appropriate language interpreter and arranges a conference call between the member, interpreter, and nurse. This person interprets the questions and answers during the call, reducing or eliminating the need for a returned phone call.
We also provide services to our hearing-impaired members through AT&T Relay Services.

Level-of-Care Recommendations

Our health information line nurses provide level-of-care information to members who call with symptom-based questions or concerns. The information provided by the caller directs the nurses, whose reference guidelines help determine the level of care that they recommend. Our nurses then help members select a course of action and an associated timeline for seeking the recommended care. Based on the caller's symptoms and responses, suggested actions may include the following:

- **Call 911 Now** - caller may decide to call 911 immediately
- **Seek Care Now** - caller may conclude that the problem will likely escalate without medical care and call their doctor immediately to discuss symptoms and arrange for care
- **Seek Care Today** - caller may conclude that the problem will probably not improve without medical care and contact their doctor that day to discuss the symptoms and arrange for care
- **Make an Appointment** - caller may conclude that the problem may not improve without medical care and make an appointment to see a doctor (in person or virtually) in the next one to two weeks
- **Try Home Treatment** - caller may decide to treat this problem at home

The nurses also provide self-care techniques and suggest how to increase member comfort levels. When callers elect home treatment, our nurses provide applicable information and suggest how to proceed if symptoms worsen or new symptoms appear.

Follow-Up Outreach

Nurses place follow-up calls to members in the following situations:

- 911 disposition
- suspected or known abuse

- attempted suicide (calls are made by our behavioral health team when clients have purchased their services; otherwise, the health information line nurses provide the follow-up outreach)

Chat with a Nurse

We have implemented chat capabilities so our members can connect with a health information line nurse Monday through Friday from 9:00 a.m. to 8:00 p.m. (EST), excluding holidays, through myCigna (web or mobile app chat functionality). Members can still call the health information line 24 hours a day every day of the year, including weekends and holidays.

Audio Health Information Library

Members can call a toll-free phone number and access an extensive list of audio library topics at any time. The health information line provides reliable, user-friendly information on more than 300 of the most broadly requested wellness, health, disease, and medical test subjects. Information about the most frequently requested topics is also available in Spanish.
Members can also read or listen to the same health information online. Members can download content in the form of podcasts via web technologies, such as streaming media and other services.

Doctor and Facility Information

Health information line nurses help callers locate a doctor if they do not have one. Nurses will also locate contracted network providers (e.g., doctors, hospitals, facilities) even when callers are outside of their own network service areas.

Integration with Cigna's Clinical Programs

The health information line's data system seamlessly integrates with Cigna's health advocacy programs. When a health information line nurse is speaking with a member, the nurse can view the Cigna programs available to that member and refer them to the appropriate program. These programs include internet resources, case management, Your Health First® chronic condition coaching, health advocacy programs (e.g., Cigna Health Advisor, lifestyle management programs), and EAP services.
Should someone contact the health information line wishing to precertify a service during utilization management nonbusiness hours, the nurse verifies eligibility, takes basic demographic information, documents the precertification request, and sends it to the utilization management department the next business day for review. Nurses document precertification services in the clinical data system to facilitate certification of coverage at a later date. The combination of these services positively impacts the quality of care that our members receive as well as the various costs associated with that care.

Cigna Implementation Guide
Implementation Project Plan

Client Name; City of Coral Gables
Account Number: 3343004
Effective Date: 01/01/2025

	Responsibility						
Task	**Cigna**	**Client Name**	**TPV Eligibility**	**Start Date**	**Target Completion Date**	**Actual Completion Date**	**Comments**
Notification of Sale		**X**		9/2/2024	9/13/2024		*These dates are subject to change depending on City's schedule.*
Hold Customer Interface Session (CIS) (Discuss benefits, HIPAA elections, reporting, structure, billing, eligibility, pre- and post-enrollment materials, claim forms, ID cards, schedule on- going weekly implementation status calls)	X	X	X	9/13/2024	9/20/2024		
Provide Initial Benefit Summaries				9/13/2024	10/4/2024		
Provide updated Admininstrative Summary with changes from the Implementation Meeting	X			9/20/2024	9/27/2024		
Provide updated Structure with changes from the Implementation Meeting				9/20/2024	9/27/2024		
Provide updated Benefit Summaries				10/4/2024	10/11/2024		
First Weekly Implementation Call Establish time and day of week for weekly calls if needed/requested.	X	X	X	TBD	TBD		*IM will schedule this call by request of the City. This may be necessary if new products are added.*
Cigna receives approval of proposed employer benefit summaries, summary of benefits and coverage, administrative summary and structure		X		10/11/2024	10/18/2024		
Plan enrollment meetings	X	X	X	TBD	TBD		
Set up the Pre-Enrollment Line. Cigna Sales will test line to ensure appropriate handling of questions. (cannot initiate set up request until employer benefits are approved.)	X			10/18/2024	11/1/2024		

Go Live Date for pre-enrollment line	X			TBD	TBD		
Account structure in production, Cigna can now accept live eligibility	X			10/18/2024	11/18/2024		
Conduct Enrollment meetings Open Enrollment Period -	X	X	X	TBD	TBD		
Provide ID Card Pre-Proofs to the Client for review and approval	X			11/18/2024	11/25/2024		
Submit open enrollment eligibility to Cigna		X	X	11/18/2024	11/19/2024		
Load open enrollment eligibility into Cigna's eligibility system	X			11/19/2024	11/26/2024		
Release eligibility to ID card vendor for production	X			11/26/2024	11/27/2024		*Dates contingent on the file date from vendor*
All ID Medical cards are in the mail	X			11/29/2024	12/9/2024		*Dependent on eligibility file complete.*
Call ready	X			11/18/2024	12/4/2024		
Claim system released	X			11/25/2024	1/10/2025		
Review and approve benefit description certificate draft(s)		X		1/2/2025	2/17/2025		*Completion is dependent on the client review and any updates needed.*

The dates included in this Implementation Project Plan are subject to change. If a change is necessary, Cigna will work with you to reach a new agreement that reflects the changes in circumstances.

The term "Cigna" refers to the various entities which will provide the coverage and/or services described, including, but not limited to, Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna HealthCare, Cigna Dental, Intracorp, and Cigna Behavioral Care.

The City of Coral Gables
Procurement Division
2800 S.W. 72ND AVENUE
MIAMI, FLORIDA 33155

CITY OF CORAL GABLES REFERENCE FORM
RFP No. 2024-020 GROUP MEDICAL INSURANCE SERVICES

Complete the form as indicated below, to provide the required information as outlined in Section 3 of the solicitation. The City shall contact the firms listed below to provide references on behalf of your company. All fields must be completed.

1. Project Name/Location: City of Naples
   Owner Name: City of Naples (reference contact)
   Contact Person: Lori McCullers
   Contact Telephone No.: (239) 213-1833
   Email Address: lmccullers@naplesgov.com
   Yearly Budget/Cost: Annual Premium = $1,901,242
   Dates of Contract: From: 10/1/2006 To: Current
   Project Description: Medical, Pharmacy, Stop Loss, FSA, Dental, EAP

2. Project Name/Location: Palm Beach County Sheriff's Office
   Owner Name: Palm Beach County Sheriff's Office (reference contact)
   Contact Person: Karen Thomas
   Contact Telephone No.: (561) 688-3638
   Email Address: thomaskl@pbso.org
   Yearly Budget/Cost: Annual Premium = $7,143,819
   Dates of Contract: From: 1/1/2010 To: Current
   Project Description: Medical, Pharmacy, Dental, EAP

The City of Coral Gables
Procurement Division
2800 S.W. 72ND AVENUE
MIAMI, FLORIDA 33155

3. Project Name/Location: City of Miami Beach

Owner Name: City of Miami Beach (reference contact)

Contact Person: Marvin Adams

Contact Telephone No.: (305) 670-7000 ext 26723

Email Address: marvin.adams@miamibeachfl.gov

Yearly Budget/Cost: Annual Premium = $1,013,612

Dates of Contract: From: 10/1/2016 To: Current

Project Description: Medical, Pharmacy, Dental, EAP

4. Project Name/Location: _____

Owner Name: _____

Contact Person: _____

Contact Telephone No.: _____

Email Address: _____

Yearly Budget/Cost: _____

Dates of Contract: From: _____ To: _____

Project Description: _____

5. Project Name/Location _____

Owner Name _____

Contact Person _____

Contact Telephone No. _____

Email Address: _____

Yearly Budget/Cost _____

Dates of Contract From: _____ To: _____

Project Description _____

_____

_____

6. Project Name/Location _____

Owner Name _____

Contact Person _____

Contact Telephone No. _____

Email Address: _____

Yearly Budget/Cost _____

Dates of Contract From: _____ To: _____

Project Description _____

_____

_____

Cigna Healthcare is currently executing a contract as the PRIME for the City of Coral Gables that derived from RFP #2019-019 which began on January 1, 2020 and will expire on December 31, 2024.

Due to contractual obligations, Cigna Healthcare is unable to provide contact information for our clients without their permission. Below is a list of our current public sector clients.

	Eligible Employees
Miami-Dade County Public Schools	30730
The School Board of Orange County, Florida	21322
The Government of the US Virgin Islands	17500
Orange County Board of County Commissioners	10000
The School Board of Brevard County	9067
The Florida Schools Retiree Benefits Consortium	8899
Brevard County Board of County Commissioners	8666
EduServe, Inc.	8252
The School Board of Seminole County Florida	7400
Hillsborough County Board of County Commissioners	6398
Collier County Public Schools	5410
Pinellas County Board of Commissioners	4930
Palm Beach County Sheriff's Office	4500
Volusia County Government	3186
City of Miami Beach	2750
Orange County Sheriff's Office	2600
City of Hollywood, Florida	2512
Martin County School District	2300
City of Miami	2265
Collier County Government	2195
The City of West Palm Beach	2091
City of Coral Springs	2083
City of Fort Lauderdale	2067
Lee County Sheriff's Office	2000
South Florida Water Management District	1765
Osceola County Government	1750
City of Clearwater	1666
Seminole County Board of County Commissioners	1520
Charlotte County Board of County Commissioners	1450
Broward College	1442
Greater Orlando Aviation Authority	1339
City of Delray Beach	1260
IAFF Local 587 Health Insurance Trust Fund	1200
City of Kissimmee	1050

Central Florida Regional Transportation Authority (LYNX)	1022
Highlands County Board of County Commissioners	977
Osceola County Sheriff's Office	933
Stetson University	892
City of Palm Bay	829
Hillsborough Transit Authority (HART)	750
Clerk of the Circuit Court & Comptroller, Palm Beach County	687
Virgin Islands Water & Power Authority	650
City of Margate	607
City of Cocoa	600
Pinellas Suncoast Transit Authority	574
Southeastern University	564
City of St. Cloud	543
City of Deerfield Beach	537
City of Naples	533
City of Winter Park	533
City of Key West	525
City of Coral Gables	512
Town of Palm Beach	504
City of Pinellas Park	499
Reedy Creek Improvement District	471
Kissimmee Utility Authority	450
City of Altamonte Springs	446
City of Tamarac	404
City of Coconut Creek	400
City of Lake Worth Beach, Florida	344
City of New Port Richey	337
Village of Wellington	324
Flagler County Sheriff's Office	316
Palm Beach County Tax Collector	307
City of Clermont	301
National University College	278
Keys Energy Services	274
City of Rockledge	260
City of Stuart	254
City Of Cocoa Beach	252
The Schools of McKeel Academy	247
Remington College	242

Saint Thomas University	240
Berkeley Preparatory School	238
Firefighters of Boca Raton	237
City of Sunny Isles Beach	218
City of Maitland	215
Canaveral Port Authority	196
City of Marco Island	193
Seminole County Clerk of the Circuit Court & Comptroller	184
The Convent of the Sacred Heart of Miami, Inc.	173
City of Sebring	168
The Cushman School	167
Osceola County Clerk of the Circuit Court	161
Lakeland Area Mass Transit District	155
Village of North Palm Beach	152
SAE Institute Group,Inc	148
Town of Medley	143
City of West Melbourne	134
Moby Benefits dba MobyMax	134
The City of Oldsmar	132
Seacoast Utility Authority	124
Town of Surfside	122
City of Atlantic Beach	121
City Of Titusville	118
City of Brooksville	117
St Lucie County Tax Collector	113
Florida Keys Mosquito Control District	112
Islamorada, Village of Islands	110
South Trail Fire Protection and Rescue Service District	101
City of Parkland	98
City of Marathon	96
Lake Worth Drainage District	87
Southern Manatee Fire & Rescue District	87
Village of Royal Palm Beach	85
City of Daytona Beach Shores	82
Indian Trail Improvement District	82
Loxahatchee River District	78
Ave Maria School of Law	65
San Carlos Park Fire Protection and Rescue Service District	61

Space Florida	54
St Lucie West Services District	53
Town of Miami Lakes	52
East Lake Tarpon Special Fire Control District	45
Matlacha-Pine Island Fire Control District	35
City of Fellsmere	27
City of West Park	26

1. **Project Name/Location: Document Storage Systems, Inc.**

   Contact Person: Debra Borheck

   Contact Telephone No. (561) 284-7116

   Email Address: dborheck@dssinc.com

   Dates of Contract From: 7/1/2014 – 6/30/2024

   Project Description: Medical, Pharmacy, Dental, Vision

2. **Project Name/Location: Stetson University**

   Contact Person: C Drew Macan

   Contact Telephone No. (386) 822-7472

   Email Address: cmacan@stetson.edu

   Dates of Contract From: 1/1/2021 – 12/31/2023

   Project Description: Medical, Pharmacy

LEGAL INFORMATION:

Please identify each incident within the last five (5) years where a civil, criminal, administrative, other similar proceeding was filed or is pending, if such proceeding arises from or is a dispute concerning the Proposer's rights, remedies or duties under a contract for the same or similar type services to be provided under this RFP (*See Affidavit D*).

Our business is a heavily regulated industry. We are subject to numerous regular inquiries and oversight by various state and federal authorities. When one of our companies is presented with regulatory inquiries, it is our policy to cooperate fully to resolve any issues. To the best of our knowledge and belief, neither Cigna, nor any of its principals, officers, or directors are involved in any federal, state, or other governmental investigation concerning criminal or quasi-criminal violations. Please refer to Form 10-K and Form 10-Q for an updated description of material legal proceedings. These documents are available online: https://www.cigna.com/about-us/investors/.

Has your company ever been debarred or suspended from doing business with any government entity? No X

Cigna certifies to the best of its knowledge and belief, that neither the bidding entities nor its principals have been debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency for the services contemplated under this proposal.

A Renewal Proposal for:

City of Coral Gables
3343004
1/1/2025

Last Modified: 7/8/2024

Date Printed: 7/25/2024

City of Coral Gables

Q1P1 Renewal 2.9% - Insured Fully Insured Plus

1/1/2025

Current and Proposed Rates

Base Tier	Subscribers	Current Unpooled	EPB	Access Fees	BAF	CDHP Fees	Total Rate
Employee	352	$ 905.86	$ 165.98	$ 25.02	$ 0.00	$ 0.00	$ 1,096.86
Emp + Spouse	24	$ 1,555.01	$ 315.34	$ 25.02	$ 0.00	$ 0.00	$ 1,895.37
Emp + Child(ren)	44	$ 1,424.93	$ 265.56	$ 25.02	$ 0.00	$ 0.00	$ 1,715.51
Emp + Family	45	$ 1,765.58	$ 441.51	$ 25.02	$ 0.00	$ 0.00	$ 2,232.11
Annual Total	**465**	**$ 5,979,972**	**##########**	**$ 139,612**	**$ 0**	**$ 0**	**$ 7,290,132**
Change							

Base Tier	Proposed Unpooled	EPB	Access Fees	BAF	CDHP Fees	Total Rate
Employee	$ 916.92	$ 186.73	$ 25.02	$ 0.00	$ 0.00	$ 1,128.67
Emp + Spouse	$1,570.56	$ 354.76	$ 25.02	$ 0.00	$ 0.00	$ 1,950.34
Emp + Child(ren)	$1,441.48	$ 298.76	$ 25.02	$ 0.00	$ 0.00	$ 1,765.26
Emp + Family	$1,775.12	$ 496.70	$ 25.02	$ 0.00	$ 0.00	$ 2,296.84
	$ 6,045,058	**$ 1,316,882**	**$ 139,612**	**$ 0**	**$ 0**	**$ 7,501,551**
	1.1 %	**12.5 %**	**-**			**2.9 %**

Buy Up Tier	Subscribers	Current Unpooled	EPB	Access Fees	BAF	CDHP Fees	Total Rate
Employee	2	$ 1,099.17	$ 169.56	$ 25.02	$ 0.00	$ 0.00	$ 1,293.75
Emp + Spouse	3	$ 1,888.41	$ 322.17	$ 25.02	$ 0.00	$ 0.00	$ 2,235.60
Emp + Child(ren)	1	$ 1,661.00	$ 271.29	$ 25.02	$ 0.00	$ 0.00	$ 1,957.31
Emp + Family	1	$ 2,156.71	$ 451.04	$ 25.02	$ 0.00	$ 0.00	$ 2,632.77
Annual Total	**7**	**$ 140,175**	**$ 24,336**	**$ 2,102**	**$ 0**	**$ 0**	**$ 166,613**
Change							

Buy Up Tier	Proposed Unpooled	EPB	Access Fees	BAF	CDHP Fees	Total Rate
Employee	$ 1,115.49	$ 190.76	$ 25.02	$ 0.00	$ 0.00	$ 1,331.27
Emp + Spouse	$1,912.97	$ 362.44	$ 25.02	$ 0.00	$ 0.00	$ 2,300.43
Emp + Child(ren)	$1,683.85	$ 305.20	$ 25.02	$ 0.00	$ 0.00	$ 2,014.07
Emp + Family	$2,176.68	$ 507.42	$ 25.02	$ 0.00	$ 0.00	$ 2,709.12
	$ 141,965	**$ 27,378**	**$ 2,102**	**$ 0**	**$ 0**	**$ 171,444**
	1.3 %	**12.5 %**	**-**			**2.9 %**

OAP (PPO) Tier	Subscribers	Current Unpooled	EPB	Access Fees	BAF	CDHP Fees	Total Rate
Employee	11	$ 1,260.56	$ 168.20	$ 25.02	$ 0.00	$ 0.00	$ 1,453.78
Emp + Spouse	2	$ 2,167.53	$ 319.58	$ 25.02	$ 0.00	$ 0.00	$ 2,512.13
Emp + Child(ren)	-	$ 1,980.69	$ 269.12	$ 25.02	$ 0.00	$ 0.00	$ 2,274.83
Emp + Family	1	$ 2,486.00	$ 447.40	$ 25.02	$ 0.00	$ 0.00	$ 2,958.42
Annual Total	**14**	**$ 248,247**	**$ 35,241**	**$ 4,203**	**$ 0**	**$ 0**	**$ 287,691**
Change							

OAP (PPO) Tier	Proposed Unpooled	EPB	Access Fees	BAF	CDHP Fees	Total Rate
Employee	$ 1,281.69	$ 189.23	$ 25.02	$ 0.00	$ 0.00	$ 1,495.94
Emp + Spouse	$2,200.43	$ 359.53	$ 25.02	$ 0.00	$ 0.00	$ 2,584.98
Emp + Child(ren)	$2,013.02	$ 302.76	$ 25.02	$ 0.00	$ 0.00	$ 2,340.80
Emp + Family	$2,515.86	$ 503.33	$ 25.02	$ 0.00	$ 0.00	$ 3,044.21
	$ 252,184	**$ 39,647**	**$ 4,203**	**$ 0**	**$ 0**	**$ 296,034**
	1.6 %	**12.5 %**	**-**			**2.9 %**

GRAND TOTAL	**486**	**$ 6,368,394**	**$ 1,230,125**	**$ 145,917**	**$ 0**	**$ 0**	**$ 7,744,436**
Change							

GRAND TOTAL	**$ 6,439,206**	**$ 1,383,906**	**$ 145,917**	**$ 0**	**$ 0**	**$ 7,969,029**
Change	**1.1 %**	**12.5 %**	**0.0 %**	**0.0 %**	**0.0 %**	**2.9 %**

Date Printed: 7/25/2024

Proposed Renewal Terms and Conditions

A. General Terms of this Renewal Proposal

Cigna HealthCare is pleased to present this Proposal for renewal for an Insured group Medical, Pharmacy, and Behavioral Health benefit plan (the "Plan") sponsored by City of Coral Gables. This proposal is valid for 60 days from its original date of release, 7/8/2024. Any revisions or updates made to this proposal will not renew this valid timeframe unless expressly communicated by Cigna Healthcare.

The information contained in this Proposal by Cigna HealthCare is being provided with the understanding that It will not be used by the employer, its representatives or consultants for any purpose other than the evaluation of The Proposal. Under no circumstances is any of the information contained herein (including excerpts, summaries, extracts, and evaluations thereof) to be used, disseminated, disclosed or otherwise communicated to any person or entity other than The employer, its representatives and consultants, and their respective employees who are directly involved in the evaluation process.

Renewal Caveats

Cigna HealthCare may revise or withdraw this renewal proposal if:

- there is a change to the effective date and/or duration of the period covered by the quote.
- Plan modifications are requested
- less than 200 employees or less than 70% of total eligible employees enroll in the Plan.
- the employer changes its level of contribution toward the cost of the coverage
- enrollment increases or decreases by 10% or more, by product, or for the total account, from the enrollment assumptions used in establishing the rates, fees, funds, and/or fee holidays set forth herein.
- Benefit Advisor Fees are requested to be different than Net
- it is requested to interface with a third party vendor
- administration of the Plan will require more than the following:
    - Billing lines : 9
    - Billing and Claim Branch Benefit Options: 36
- it is not the exclusive provider of Medical, Pharmacy, Behavioral Health, or like products for all of City of Coral Gables employees in all worksites
- the Experience Protection Benefit has a pooling point other than $100,000
- there is any reimbursement arrangement ("gap" cards, etc.) that subsidizes or reduces the out-of-pocket obligation of covered persons under the policy.

B. Scope and Application of this Proposal

Unless otherwise indicated, this Proposal:

- assumes that the group health plan or health insurance coverage to which this proposal applies will not be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Act") and that it will be subject to all requirements of the Act applicable to a group health plan or health insurance coverage unless otherwise specified in writing.

- includes applicable Patient Protection and Affordable Care Act fees and assessments imposed upon health insurers including the Comparative Effectiveness Research Fee and the Health Insurance Industry Fee.

- supersedes and renders null and void any prior Cigna HealthCare offer or proposal with respect to the Plan

- presents financial terms that must be accepted on a packaged basis

- reflects the claims and administrative savings realized by packaging the following specialty coverages with medical: Pharmacy, Behavioral Health

- does not apply to retirees 65 or older for managed care Plans or part-time or seasonal employees for any plan

- includes fixed charges for behavioral care services arranged by Evernorth Behavioral Health, Inc. or Evernorth Care Solutions, Inc. The fixed fee varies depending on location and plan design and may not apply in certain states.

- includes capitated charges for the provision of Hi-Tech Radiology services by eviCore (formerly known as MedSolutions, Inc.). Reimbursement methodology varies by state.

- Includes charges made by either a specialty vendor or an affiliate, such as eviCore for care management programs to contain the cost of specific health services/items and/or improve adherence to evidence-based guidelines to promote patient safety and efficient care (i.e., charges for management of diagnostic cardiology, radiation therapy, musculoskeletal procedures, medical oncology, gastroenterology, sleep management and home health/DME/HIT and appropriate setting of care/service) when applicable, and medical necessity review (i.e chiropractic services).

- requires a separate benefit option due to state regulations, if you have purchased any product with Cigna Total Behavioral Health and you have customers residing in CA or VI.

- Notwithstanding the foregoing guarantee, Cigna may revise any charges at any time if Cigna is (i) required to pay any tax or assessment, or (ii) incur additional costs in administering the contract as a result of any state or federal law.

- guarantees the expenses for the settlement accounting at the end of the policy year (as determined by Cigna) are to be 12.27% of the experience rated premium unless the Proposal Caveats are not met or maintained or there is either a bank account or retro call.

- includes the Network Savings Program (NSP) and other Cost Containment programs designed to contain costs with respect to charges for health care services/supplies that are covered by the Plan. For administering these programs, Cigna retains a portion of the savings or recoveries generated.

- excludes charges for converting a qualified customer of a group plan to an individual plan.

- includes a maximum reimbursable charge for out-of-network coverage equal to 0.0% of a fee schedule developed by Cigna HealthCare based upon a methodology similar to that used by Medicare to determine the allowable fee for similar services in the geographic market or 80th percentile of charges made by providers of such service or supply in the geographic area where the service is received.

- assumes that Cigna HealthCare's standard insurance policy form approved for use in the applicable state by the state insurance regulator will be issued. Because the insurance policy and certificate terms require regulatory approval, there is very little flexibility to change the provisions. The provisions of the insurance policy and certificate will control in the event of a conflict with the terms of the request for proposal and the Proposal.

- the policy year to which this quotation applies, a deficit amount will not be accumulated for recovery by Cigna HealthCare. If Cigna Healthcare determines the policy period experience produced a margin, a dividend credit equal to 50% of the margin amount will be granted, provided the policy is renewed for the subsequent policy year and in force at the time the settlement is reported to you by CHLIC. The determination of the margin amount is made during the year end settlement process. This agreement to share margins does not apply:

    - if the experience rated medical policy terminates or is amended to convert to another funding option.

    - if the policy period for settlement purposes is other than 12 months.

    - the determination of the margin amount shall be made by Cigna HealthCare in accordance with its then current underwriting practices. Cigna HealthCare has the right to revise its associated risk charge if, during the policy year, there is a material change in the factors assumed by Cigna HealthCare as reflected in this proposal, or there is a change in the terms, conditions, or benefits of the polic(ies) included in your account or there is a change in the geographic location of your business or a change in the nature of your business that would in the opinion of Cigna HealthCare change the risk it assumed under the policy(ies).

- a supplementary document titled Fully Insured Plus Experience Rated Provision is included with this proposal. If you do not notify us of any objection to the administration described within 30 days of receipt of this explanation, you will be deemed to have agreed to the administration described once the Fully Insured Plus policy is effective

Assumes incentive design follows the standard guidelines offered by Cigna Healthcare. Incentive rewards will be funded by the client and certain reward types will be direct billed or withdrawn from the bank account (as applicable).

- Includes Cigna Pathwell Specialty, a network solution for medical specialty drugs.

- establishes a Wellness/Health Improvement Fund (the "Fund") in the amount of $100,000

- The Wellness/Health Improvement Fund will be used to defray the cost of Cigna designated and arranged health and wellness programs for employees (e.g., biometric screenings, flu shots, etc.) and to reward participation in wellness programs.

- Wellness/Health Improvement Fund may be accessed during the period from 01/01/2025 - 12/31/2025. The Fund may not be accessed following notice of termination of the Cigna HealthCare agreement. Unused Funds Cannot be rolled over and Cigna HealthCare must pre-approve use of the Fund.

- Assumes a non-Cigna HealthCare Pharmacy Benefit Manager administers oral or other self-administered anti-cancer prescription medication claims at a copayment/coinsurance level that is no less favorable than that for intravenous or injected anti-cancer medication prescribed for the same purpose and covered under employer's Cigna HealthCare plan. This assumption is applicable only if: (a) employer has contracted with a PBM (not Cigna HealthCare); (b) employer's plan is either insured, or, if self-funded, not subject to ERISA (i.e., is a church, government or association plan); and (c) employer's Cigna HealthCare plan is situsued in IA, HI, NM, OR, NJ, NE, VA, MA, NV, FL, ME, GA or a state with similar chemotherapy coverage law, or covers one or more individuals residing in CO, OK, VT, WA, TX, LA, MO, OH or in a state with similar extraterritorial chemotherapy coverage mandate.

- does not apply to individuals unless employed by the policyholder or an entity that participates in an association or trust that is the policyholder.

- assumes that any non-voluntary vision benefit that is included in the medical plan and not provided through a separate policy is subject to ACA requirements.

- includes Cigna's One Guide digital and customer guidance solution.

For CIGNA HealthCare of Arizona, Inc. and Cigna Health & Life Insurance Company (CHLIC) insured group plans, groups that have at least 12,000 member months in their claims experience period and a minimum of six consecutive months of claims experience are rated using adjusted community rating (ACR), which applies full credibility to group specific medical claims experience. Groups between 600 and 12,000 member months in their claims experience period and a minimum of six consecutive months of claims experience are rated based upon a meld of ACR and CRC. Groups with more than 50 employees and less than 600 member months in their claims experience period are rated using CRC.

Important Notice Regarding Benefit Advisor Compensation - The premium for this Shared Returns policy may not include compensation payable to your benefit advisor. Check with your Cigna Sales representative to confirm whether this is the case. When that is the case, the proposed billed amount includes both premium and benefit advisor fees, which are not part of the monthly premium and Cigna will include any benefit advisor fees agreed to by the client and benefit advisor on client invoices and forward payments received to the benefit advisor if both the client and the benefit advisor authorize Cigna to do so by signing Cigna's Client and Benefit Advisor Acknowledgement Form. When required, this form must be signed before the date when the new rates take effect. If the form is not signed, the benefit advisor will be responsible for billing the client directly for any benefit advisor fees.

C. Additional Representations & Disclosures

The plans presented in this proposal have an actuarial value, determined by Cigna HealthCare, of 60% or greater. This determination was made using Cigna HealthCare's manual rating application which may produce an actuarial value slightly different than the official HHS calculator. Although we would expect any deviation to be small, you will have to consult with your actuarial consultant for a more precise determination of the plan's actuarial value. Cigna HealthCare does not provide actuarial certifications.

Cigna Healthcare may pay on your behalf any applicable state tax or assessment imposed upon your plan by drawing upon the bank account.

In order to implement the requested benefit design, different funding arrangements (i.e., insured, self-insured and/or HMO) involving affiliated Cigna companies may be required with respect to plan participants residing in certain states.

Cigna HealthCare may have an agreement with your benefit advisor, under which the benefit advisor may be paid for providing marketplace intelligence or for the performance of administrative services. The qualification for and amount of this payment may be based upon overall business growth and/or retention levels. Any such payment is funded through Cigna HealthCare's general overhead.

The benefit advisor may qualify for incentive payment (monetary or non-monetary) from Cigna HealthCare. For example, the benefit advisor may receive payment based upon new sales, new customer growth or retention. This incentive payment is funded from Cigna HealthCare's general overhead.

Cigna HealthCare sponsors programs to inform benefit advisors about Cigna HealthCare's plan coverage and services (including producer advisory councils). The cost of these events is funded through Cigna HealthCare's general overhead.

Includes Fixed Charges for Embarc Benefit Protection[SM], a network solution for certain high-cost gene therapy drugs arranged by eviCore.

Cigna HealthCare reserves the right to change the Quoted Rates and/or Quoted Benefits or to decline to offer coverage if any of the foregoing information is inaccurate or changes prior to the proposed Effective Date indicated above, or if the quoted rates and/or fees are not agreed to within 60 days of receipt of this summary information form. If any of the information identified above changes either prior to the proposed Effective Date or while coverage is in effect, you agree to notify us promptly of such change.

The "Underwriting Contingencies" set forth above shall survive execution of any insurance policy, application, etc., issued by Cigna HealthCare or any affiliated company, and shall further survive the effective date of any such policies.

Cigna will administer the Insured Fully Insured Plus (i.e.,experience-rated) policy which is the subject of this proposal as explained below.

Experience-rating is the process by which the Cigna underwriter establishes the premium rate for the upcoming policy period using the claim and expense experience of the previous policy period. Due to the fact that the policyholder participates in the risk through the experience-rating process, experience-rated policies are also referred to as "participating." Cigna contracts covering the same group will be treated as a single experience program for experience-rating purposes. (This may include contracts issued by affiliated Cigna companies such as HMOs)

Following the end of a policy period (typically a 12 month period), the Cigna underwriter completes a settlement for that policy period to determine whether there is a Margin or a Deficit. "Margin" means any excess of premium over claim payments, changes in reserve liability, premium taxes, claim handling and any administrative expenses. "Deficit" means the excess of claim payments, including changes in reserve liability, premium taxes, claim handling and any administrative expense over premium. Administrative expenses will be applied in the settlement calculation using the guaranteed expense percentage reflected in the terms and conditions section of the financial proposal. Access fees and pooled premium and claims are excluded from the settlement calculation.

If the policy period experience produces a Margin, a dividend credit equal to 50% of the Margin amount will be granted to the policyholder, provided the policy is renewed for the subsequent policy year and the policy is in effect at the time the settlement is reported to the policyholder.. The credit may be in the form of a return of premium for the prior policy period, a reduction in the premium that would otherwise be charged for the next policy, or both. The margin can also be placed in a "Premium Stabilization Reserve" or "PSR" and used to offset future premium charges.

Margins accumulate interest at an annual rate established by Cigna. Margins credited to a PSR by Cigna are credited with interest until the funds are used for the payment of policy premium and/or the PSR is terminated. Interest charges/credits are incorporated when setting the administrative expense component of the rates.

Summary of the Insured Fully Insured Plus experience-rated provision:

- Following the end of the policy period, the Cigna underwriter will complete a settlement to determine whether the policy year ended in a Margin or Deficit.
- Margins result in a credit to the policyholder of 50% of the Margin amount, provided the policy is renewed in the subsequent policy year and the policy is in effect at the time the settlement is reported to the policyholder.
- If a Deficit occurs, the Deficit amount will not be recovered from prior policy year Margins nor will be carried forward to be recovered from future policy year Margins.

If you have any questions regarding the administration of the experience-rating process, please contact your Cigna Sales Representative immediately. If you do not notify us of any objection to the administration described within 30 days of receipt of this explanation, you will be deemed to have agreed to the administration described once the Shared Returns policy is effective.

A Renewal Proposal for:

City of Coral Gables

3343004

1/1/2025

Alternate 1

Last Modified: 7/10/2024

Date Printed: 7/25/2024

City of Coral Gables

Q1P2 Alt 1 - Insured Fully Insured Plus

1/1/2025

Current and Proposed Rates

Base Tier	Subscribers	Current Total Rate
Employee	352	$ 1,096.86
Emp + Spouse	24	$ 1,895.37
Emp + Child(ren)	44	$ 1,715.51
Emp + Family	45	$ 2,232.11
Annual Total	**465**	**$ 7,290,132**
Change		

Base Tier	Proposed Total Rate
Employee	$ 1,104.45
Emp + Spouse	$ 1,908.49
Emp + Child(ren)	$ 1,727.38
Emp + Family	$ 2,247.56
	$ 7,340,581
	0.7 %

Buy Up Tier	Subscribers	Current Total Rate
Employee	2	$ 1,293.75
Emp + Spouse	3	$ 2,235.60
Emp + Child(ren)	1	$ 1,957.31
Emp + Family	1	$ 2,632.77
Annual Total	**7**	**$ 166,613**
Change		

Buy Up Tier	Proposed Total Rate
Employee	$ 1,331.29
Emp + Spouse	$ 2,300.48
Emp + Child(ren)	$ 2,014.11
Emp + Family	$ 2,709.17
	$ 171,448
	2.9 %

OAP (PPO) Tier	Subscribers	Current Total Rate
Employee	11	$ 1,453.78
Emp + Spouse	2	$ 2,512.13
Emp + Child(ren)	-	$ 2,274.83
Emp + Family	1	$ 2,958.42
Annual Total	**14**	**$ 287,691**
Change		

OAP (PPO) Tier	Proposed Total Rate
Employee	$ 1,495.97
Emp + Spouse	$ 2,585.03
Emp + Child(ren)	$ 2,340.85
Emp + Family	$ 3,044.27
	$ 296,040
	2.9 %

GRAND TOTAL	**486**	**$ 7,744,436**
Change		

GRAND TOTAL	**$ 7,808,069**
Change	**0.8 %**

Date Printed: 7/25/2024

Proposed Renewal Terms and Conditions

A. General Terms of this Renewal Proposal

Cigna HealthCare is pleased to present this Proposal for renewal for an Insured group Medical, Pharmacy, and Behavioral Health benefit plan (the "Plan") sponsored by City of Coral Gables. This proposal is valid for 60 days from its original date of release, 7/8/2024. Any revisions or updates made to this proposal will not renew this valid timeframe unless expressly communicated by Cigna Healthcare.

The information contained in this Proposal by Cigna HealthCare is being provided with the understanding that It will not be used by the employer, its representatives or consultants for any purpose other than the evaluation of The Proposal. Under no circumstances is any of the information contained herein (including excerpts, summaries, extracts, and evaluations thereof) to be used, disseminated, disclosed or otherwise communicated to any person or entity other than The employer, its representatives and consultants, and their respective employees who are directly involved in the evaluation process.

Renewal Caveats

Cigna HealthCare may revise or withdraw this renewal proposal if:

- there is a change to the effective date and/or duration of the period covered by the quote.
- Plan modifications are requested
- less than 200 employees or less than 70% of total eligible employees enroll in the Plan.
- the employer changes its level of contribution toward the cost of the coverage
- enrollment increases or decreases by 10% or more, by product, or for the total account, from the enrollment assumptions used in establishing the rates, fees, funds, and/or fee holidays set forth herein.
- Benefit Advisor Fees are requested to be different than Net
- it is requested to interface with a third party vendor
- administration of the Plan will require more than the following:
    - Billing lines : 9
    - Billing and Claim Branch Benefit Options: 36
- it is not the exclusive provider of Medical, Pharmacy, Behavioral Health, or like products for all of City of Coral Gables employees in all worksites
- the Experience Protection Benefit has a pooling point other than $100,000
- there is any reimbursement arrangement ("gap" cards, etc.) that subsidizes or reduces the out-of-pocket obligation of covered persons under the policy.

B. Scope and Application of this Proposal

Unless otherwise indicated, this Proposal:

- assumes that the group health plan or health insurance coverage to which this proposal applies will not be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Act") and that it will be subject to all requirements of the Act applicable to a group health plan or health insurance coverage unless otherwise specified in writing.

- includes applicable Patient Protection and Affordable Care Act fees and assessments imposed upon health insurers including the Comparative Effectiveness Research Fee and the Health Insurance Industry Fee.

- supersedes and renders null and void any prior Cigna HealthCare offer or proposal with respect to the Plan

- presents financial terms that must be accepted on a packaged basis

- reflects the claims and administrative savings realized by packaging the following specialty coverages with medical: Pharmacy, Behavioral Health

- does not apply to retirees 65 or older for managed care Plans or part-time or seasonal employees for any plan

- includes fixed charges for behavioral care services arranged by Evernorth Behavioral Health, Inc. or Evernorth Care Solutions, Inc. The fixed fee varies depending on location and plan design and may not apply in certain states.

- includes capitated charges for the provision of Hi-Tech Radiology services by eviCore (formerly known as MedSolutions, Inc.). Reimbursement methodology varies by state.

- Includes charges made by either a specialty vendor or an affiliate, such as eviCore for care management programs to contain the cost of specific health services/items and/or improve adherence to evidence-based guidelines to promote patient safety and efficient care (i.e., charges for management of diagnostic cardiology, radiation therapy, musculoskeletal procedures, medical oncology, gastroenterology, sleep management and home health/DME/HIT and appropriate setting of care/service) when applicable, and medical necessity review (i.e chiropractic services).

- requires a separate benefit option due to state regulations, if you have purchased any product with Cigna Total Behavioral Health and you have customers residing in CA or VI.

- Notwithstanding the foregoing guarantee, Cigna may revise any charges at any time if Cigna is (i) required to pay any tax or assessment, or (ii) incur additional costs in administering the contract as a result of any state or federal law.

- guarantees the expenses for the settlement accounting at the end of the policy year (as determined by Cigna) are to be 12.30% of the experience rated premium unless the Proposal Caveats are not met or maintained or there is either a bank account or retro call.

- includes the Network Savings Program (NSP) and other Cost Containment programs designed to contain costs with respect to charges for health care services/supplies that are covered by the Plan. For administering these programs, Cigna retains a portion of the savings or recoveries generated.

- excludes charges for converting a qualified customer of a group plan to an individual plan.

- includes a maximum reimbursable charge for out-of-network coverage equal to 0.0% of a fee schedule developed by Cigna HealthCare based upon a methodology similar to that used by Medicare to determine the allowable fee for similar services in the geographic market or 80th percentile of charges made by providers of such service or supply in the geographic area where the service is received.

- assumes that Cigna HealthCare's standard insurance policy form approved for use in the applicable state by the state insurance regulator will be issued. Because the insurance policy and certificate terms require regulatory approval, there is very little flexibility to change the provisions. The provisions of the insurance policy and certificate will control in the event of a conflict with the terms of the request for proposal and the Proposal.

- the policy year to which this quotation applies, a deficit amount will not be accumulated for recovery by Cigna HealthCare. If Cigna Healthcare determines the policy period experience produced a margin, a dividend credit equal to 50% of the margin amount will be granted, provided the policy is renewed for the subsequent policy year and in force at the time the settlement is reported to you by CHLIC. The determination of the margin amount is made during the year end settlement process. This agreement to share margins does not apply:

    - if the experience rated medical policy terminates or is amended to convert to another funding option.

    - if the policy period for settlement purposes is other than 12 months.

    - the determination of the margin amount shall be made by Cigna HealthCare in accordance with its then current underwriting practices. Cigna HealthCare has the right to revise its associated risk charge if, during the policy year, there is a material change in the factors assumed by Cigna HealthCare as reflected in this proposal, or there is a change in the terms, conditions, or benefits of the polic(ies) included in your account or there is a change in the geographic location of your business or a change in the nature of your business that would in the opinion of Cigna HealthCare change the risk it assumed under the policy(ies).

- a supplementary document titled Fully Insured Plus Experience Rated Provision is included with this proposal. If you do not notify us of any objection to the administration described within 30 days of receipt of this explanation, you will be deemed to have agreed to the administration described once the Fully Insured Plus policy is effective

Assumes incentive design follows the standard guidelines offered by Cigna Healthcare. Incentive rewards will be funded by the client and certain reward types will be direct billed or withdrawn from the bank account (as applicable).

- Includes Cigna Pathwell Specialty, a network solution for medical specialty drugs.

- establishes a Wellness/Health Improvement Fund (the "Fund") in the amount of $100,000

- The Wellness/Health Improvement Fund will be used to defray the cost of Cigna designated and arranged health and wellness programs for employees (e.g., biometric screenings, flu shots, etc.) and to reward participation in wellness programs.

- Wellness/Health Improvement Fund may be accessed during the period from 01/01/2025 - 12/31/2025. The Fund may not be accessed following notice of termination of the Cigna HealthCare agreement. Unused Funds Cannot be rolled over and Cigna HealthCare must pre-approve use of the Fund.

- Assumes a non-Cigna HealthCare Pharmacy Benefit Manager administers oral or other self-administered anti-cancer prescription medication claims at a copayment/coinsurance level that is no less favorable than that for intravenous or injected anti-cancer medication prescribed for the same purpose and covered under employer's Cigna HealthCare plan. This assumption is applicable only if: (a) employer has contracted with a PBM (not Cigna HealthCare); (b) employer's plan is either insured, or, if self-funded, not subject to ERISA (i.e., is a church, government or association plan); and (c) employer's Cigna HealthCare plan is situsedin IA, HI, NM, OR, NJ, NE, VA, MA, NV, FL, ME, GA or a state with similar chemotherapy coverage law, or covers one or more individuals residing in CO, OK, VT, WA, TX, LA, MO, OH or in a state with similar extraterritorial chemotherapy coverage mandate.

- does not apply to individuals unless employed by the policyholder or an entity that participates in an association or trust that is the policyholder.

- assumes that any non-voluntary vision benefit that is included in the medical plan and not provided through a separate policy is subject to ACA requirements.

- includes Cigna's One Guide digital and customer guidance solution.

For CIGNA HealthCare of Arizona, Inc. and Cigna Health & Life Insurance Company (CHLIC) insured group plans, groups that have at least 12,000 member months in their claims experience period and a minimum of six consecutive months of claims experience are rated using adjusted community rating (ACR), which applies full credibility to group specific medical claims experience. Groups between 600 and 12,000 member months in their claims experience period and a minimum of six consecutive months of claims experience are rated based upon a meld of ACR and CRC. Groups with more than 50 employees and less than 600 member months in their claims experience period are rated using CRC.

Important Notice Regarding Benefit Advisor Compensation - The premium for this Shared Returns policy may not include compensation payable to your benefit advisor. Check with your Cigna Sales representative to confirm whether this is the case. When that is the case, the proposed billed amount includes both premium and benefit advisor fees, which are not part of the monthly premium and Cigna will include any benefit advisor fees agreed to by the client and benefit advisor on client invoices and forward payments received to the benefit advisor if both the client and the benefit advisor authorize Cigna to do so by signing Cigna's Client and Benefit Advisor Acknowledgement Form. When required, this form must be signed before the date when the new rates take effect. If the form is not signed, the benefit advisor will be responsible for billing the client directly for any benefit advisor fees.

C. Additional Representations & Disclosures

The plans presented in this proposal have an actuarial value, determined by Cigna HealthCare, of 60% or greater. This determination was made using Cigna HealthCare's manual rating application which may produce an actuarial value slightly different than the official HHS calculator. Although we would expect any deviation to be small, you will have to consult with your actuarial consultant for a more precise determination of the plan's actuarial value. Cigna HealthCare does not provide actuarial certifications.

Cigna Healthcare may pay on your behalf any applicable state tax or assessment imposed upon your plan by drawing upon the bank account.

In order to implement the requested benefit design, different funding arrangements (i.e., insured, self-insured and/or HMO) involving affiliated Cigna companies may be required with respect to plan participants residing in certain states.

Cigna HealthCare may have an agreement with your benefit advisor, under which the benefit advisor may be paid for providing marketplace intelligence or for the performance of administrative services. The qualification for and amount of this payment may be based upon overall business growth and/or retention levels. Any such payment is funded through Cigna HealthCare's general overhead.

The benefit advisor may qualify for incentive payment (monetary or non-monetary) from Cigna HealthCare. For example, the benefit advisor may receive payment based upon new sales, new customer growth or retention. This incentive payment is funded from Cigna HealthCare's general overhead.

Cigna HealthCare sponsors programs to inform benefit advisors about Cigna HealthCare's plan coverage and services (including producer advisory councils). The cost of these events is funded through Cigna HealthCare's general overhead.

Includes Fixed Charges for Embarc Benefit Protection[SM], a network solution for certain high-cost gene therapy drugs arranged by eviCore.

Cigna HealthCare reserves the right to change the Quoted Rates and/or Quoted Benefits or to decline to offer coverage if any of the foregoing information is inaccurate or changes prior to the proposed Effective Date indicated above, or if the quoted rates and/or fees are not agreed to within 60 days of receipt of this summary information form. If any of the information identified above changes either prior to the proposed Effective Date or while coverage is in effect, you agree to notify us promptly of such change.

The "Underwriting Contingencies" set forth above shall survive execution of any insurance policy, application, etc., issued by Cigna HealthCare or any affiliated company, and shall further survive the effective date of any such policies.

Cigna will administer the Insured Fully Insured Plus (i.e.,experience-rated) policy which is the subject of this proposal as explained below.

Experience-rating is the process by which the Cigna underwriter establishes the premium rate for the upcoming policy period using the claim and expense experience of the previous policy period. Due to the fact that the policyholder participates in the risk through the experience-rating process, experience-rated policies are also referred to as "participating." Cigna contracts covering the same group will be treated as a single experience program for experience-rating purposes. (This may include contracts issued by affiliated Cigna companies such as HMOs)

Following the end of a policy period (typically a 12 month period), the Cigna underwriter completes a settlement for that policy period to determine whether there is a Margin or a Deficit. "Margin" means any excess of premium over claim payments, changes in reserve liability, premium taxes, claim handling and any administrative expenses. "Deficit" means the excess of claim payments, including changes in reserve liability, premium taxes, claim handling and any administrative expense over premium. Administrative expenses will be applied in the settlement calculation using the guaranteed expense percentage reflected in the terms and conditions section of the financial proposal. Access fees and pooled premium and claims are excluded from the settlement calculation.

If the policy period experience produces a Margin, a dividend credit equal to 50% of the Margin amount will be granted to the policyholder, provided the policy is renewed for the subsequent policy year and the policy is in effect at the time the settlement is reported to the policyholder.. The credit may be in the form of a return of premium for the prior policy period, a reduction in the premium that would otherwise be charged for the next policy, or both. The margin can also be placed in a "Premium Stabilization Reserve" or "PSR" and used to offset future premium charges.

Margins accumulate interest at an annual rate established by Cigna. Margins credited to a PSR by Cigna are credited with interest until the funds are used for the payment of policy premium and/or the PSR is terminated. Interest charges/credits are incorporated when setting the administrative expense component of the rates.

Summary of the Insured Fully Insured Plus experience-rated provision:

- Following the end of the policy period, the Cigna underwriter will complete a settlement to determine whether the policy year ended in a Margin or Deficit.
- Margins result in a credit to the policyholder of 50% of the Margin amount, provided the policy is renewed in the subsequent policy year and the policy is in effect at the time the settlement is reported to the policyholder.
- If a Deficit occurs, the Deficit amount will not be recovered from prior policy year Margins nor will be carried forward to be recovered from future policy year Margins.

If you have any questions regarding the administration of the experience-rating process, please contact your Cigna Sales Representative immediately. If you do not notify us of any objection to the administration described within 30 days of receipt of this explanation, you will be deemed to have agreed to the administration described once the Shared Returns policy is effective.

A Renewal Proposal for:

City of Coral Gables

3343004

1/1/2025

Alternate 2

Last Modified: 7/10/2024

Date Printed: 7/25/2024

City of Coral Gables

Q1P3 Alt 2 - Insured Fully Insured Plus

1/1/2025

Current and Proposed Rates

Base Tier	Subscribers	Current Total Rate
Employee	352	$ 1,096.86
Emp + Spouse	24	$ 1,895.37
Emp + Child(ren)	44	$ 1,715.51
Emp + Family	45	$ 2,232.11
Annual Total	**465**	**$ 7,290,132**
Change		

Base Tier	Proposed Total Rate
Employee	$ 1,045.14
Emp + Spouse	$ 1,806.00
Emp + Child(ren)	$ 1,634.62
Emp + Family	$ 2,126.87
	$ 6,946,389
	(4.7 %)

Buy Up Tier	Subscribers	Current Total Rate
Employee	2	$ 1,293.75
Emp + Spouse	3	$ 2,235.60
Emp + Child(ren)	1	$ 1,957.31
Emp + Family	1	$ 2,632.77
Annual Total	**7**	**$ 166,613**
Change		

Buy Up Tier	Proposed Total Rate
Employee	$ 1,331.31
Emp + Spouse	$ 2,300.50
Emp + Child(ren)	$ 2,014.13
Emp + Family	$ 2,709.20
	$ 171,449
	2.9 %

OAP (PPO) Tier	Subscribers	Current Total Rate
Employee	11	$ 1,453.78
Emp + Spouse	2	$ 2,512.13
Emp + Child(ren)	-	$ 2,274.83
Emp + Family	1	$ 2,958.42
Annual Total	**14**	**$ 287,691**
Change		

OAP (PPO) Tier	Proposed Total Rate
Employee	$ 1,495.91
Emp + Spouse	$ 2,584.93
Emp + Child(ren)	$ 2,340.75
Emp + Family	$ 3,044.16
	$ 296,028
	2.9 %

GRAND TOTAL	**486**	**$ 7,744,436**
Change		

GRAND TOTAL	**$ 7,413,866**
Change	**(4.3 %)**

Date Printed: 7/25/2024

Proposed Renewal Terms and Conditions

A. General Terms of this Renewal Proposal

Cigna HealthCare is pleased to present this Proposal for renewal for an Insured group Medical, Pharmacy, and Behavioral Health benefit plan (the "Plan") sponsored by City of Coral Gables. This proposal is valid for 60 days from its original date of release, 7/8/2024. Any revisions or updates made to this proposal will not renew this valid timeframe unless expressly communicated by Cigna Healthcare.

The information contained in this Proposal by Cigna HealthCare is being provided with the understanding that It will not be used by the employer, its representatives or consultants for any purpose other than the evaluation of The Proposal. Under no circumstances is any of the information contained herein (including excerpts, summaries, extracts, and evaluations thereof) to be used, disseminated, disclosed or otherwise communicated to any person or entity other than The employer, its representatives and consultants, and their respective employees who are directly involved in the evaluation process.

Renewal Caveats

Cigna HealthCare may revise or withdraw this renewal proposal if:

- there is a change to the effective date and/or duration of the period covered by the quote.
- Plan modifications are requested
- less than 200 employees or less than 70% of total eligible employees enroll in the Plan.
- the employer changes its level of contribution toward the cost of the coverage
- enrollment increases or decreases by 10% or more, by product, or for the total account, from the enrollment assumptions used in establishing the rates, fees, funds, and/or fee holidays set forth herein.
- Benefit Advisor Fees are requested to be different than Net
- it is requested to interface with a third party vendor
- administration of the Plan will require more than the following:
    - Billing lines : 9
    - Billing and Claim Branch Benefit Options: 36
- it is not the exclusive provider of Medical, Pharmacy, Behavioral Health, or like products for all of City of Coral Gables employees in all worksites
- the Experience Protection Benefit has a pooling point other than $100,000
- there is any reimbursement arrangement ("gap" cards, etc.) that subsidizes or reduces the out-of-pocket obligation of covered persons under the policy.

B. Scope and Application of this Proposal

Unless otherwise indicated, this Proposal:

- assumes that the group health plan or health insurance coverage to which this proposal applies will not be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Act") and that it will be subject to all requirements of the Act applicable to a group health plan or health insurance coverage unless otherwise specified in writing.

- includes applicable Patient Protection and Affordable Care Act fees and assessments imposed upon health insurers including the Comparative Effectiveness Research Fee and the Health Insurance Industry Fee.

- supersedes and renders null and void any prior Cigna HealthCare offer or proposal with respect to the Plan

- presents financial terms that must be accepted on a packaged basis

- reflects the claims and administrative savings realized by packaging the following specialty coverages with medical: Pharmacy, Behavioral Health

- does not apply to retirees 65 or older for managed care Plans or part-time or seasonal employees for any plan

- includes fixed charges for behavioral care services arranged by Evernorth Behavioral Health, Inc. or Evernorth Care Solutions, Inc. The fixed fee varies depending on location and plan design and may not apply in certain states.

- includes capitated charges for the provision of Hi-Tech Radiology services by eviCore (formerly known as MedSolutions, Inc.). Reimbursement methodology varies by state.

- Includes charges made by either a specialty vendor or an affiliate, such as eviCore for care management programs to contain the cost of specific health services/items and/or improve adherence to evidence-based guidelines to promote patient safety and efficient care (i.e., charges for management of diagnostic cardiology, radiation therapy, musculoskeletal procedures, medical oncology, gastroenterology, sleep management and home health/DME/HIT and appropriate setting of care/service) when applicable, and medical necessity review (i.e chiropractic services).

- requires a separate benefit option due to state regulations, if you have purchased any product with Cigna Total Behavioral Health and you have customers residing in CA or VI.

- Notwithstanding the foregoing guarantee, Cigna may revise any charges at any time if Cigna is (i) required to pay any tax or assessment, or (ii) incur additional costs in administering the contract as a result of any state or federal law.

- guarantees the expenses for the settlement accounting at the end of the policy year (as determined by Cigna) are to be 12.37% of the experience rated premium unless the Proposal Caveats are not met or maintained or there is either a bank account or retro call.

- includes the Network Savings Program (NSP) and other Cost Containment programs designed to contain costs with respect to charges for health care services/supplies that are covered by the Plan. For administering these programs, Cigna retains a portion of the savings or recoveries generated.

- excludes charges for converting a qualified customer of a group plan to an individual plan.

- includes a maximum reimbursable charge for out-of-network coverage equal to 0.0% of a fee schedule developed by Cigna HealthCare based upon a methodology similar to that used by Medicare to determine the allowable fee for similar services in the geographic market or 80th percentile of charges made by providers of such service or supply in the geographic area where the service is received.

- assumes that Cigna HealthCare's standard insurance policy form approved for use in the applicable state by the state insurance regulator will be issued. Because the insurance policy and certificate terms require regulatory approval, there is very little flexibility to change the provisions. The provisions of the insurance policy and certificate will control in the event of a conflict with the terms of the request for proposal and the Proposal.

- the policy year to which this quotation applies, a deficit amount will not be accumulated for recovery by Cigna HealthCare. If Cigna Healthcare determines the policy period experience produced a margin, a dividend credit equal to 50% of the margin amount will be granted, provided the policy is renewed for the subsequent policy year and in force at the time the settlement is reported to you by CHLIC. The determination of the margin amount is made during the year end settlement process. This agreement to share margins does not apply:

    - if the experience rated medical policy terminates or is amended to convert to another funding option.

    - if the policy period for settlement purposes is other than 12 months.

    - the determination of the margin amount shall be made by Cigna HealthCare in accordance with its then current underwriting practices. Cigna HealthCare has the right to revise its associated risk charge if, during the policy year, there is a material change in the factors assumed by Cigna HealthCare as reflected in this proposal, or there is a change in the terms, conditions, or benefits of the polic(ies) included in your account or there is a change in the geographic location of your business or a change in the nature of your business that would in the opinion of Cigna HealthCare change the risk it assumed under the policy(ies).

- a supplementary document titled Fully Insured Plus Experience Rated Provision is included with this proposal. If you do not notify us of any objection to the administration described within 30 days of receipt of this explanation, you will be deemed to have agreed to the administration described once the Fully Insured Plus policy is effective

Assumes incentive design follows the standard guidelines offered by Cigna Healthcare. Incentive rewards will be funded by the client and certain reward types will be direct billed or withdrawn from the bank account (as applicable).

- Includes Cigna Pathwell Specialty, a network solution for medical specialty drugs.

- establishes a Wellness/Health Improvement Fund (the "Fund") in the amount of $100,000

- The Wellness/Health Improvement Fund will be used to defray the cost of Cigna designated and arranged health and wellness programs for employees (e.g., biometric screenings, flu shots, etc.) and to reward participation in wellness programs.

- Wellness/Health Improvement Fund may be accessed during the period from 01/01/2025 - 12/31/2025. The Fund may not be accessed following notice of termination of the Cigna HealthCare agreement. Unused Funds Cannot be rolled over and Cigna HealthCare must pre-approve use of the Fund.

- Assumes a non-Cigna HealthCare Pharmacy Benefit Manager administers oral or other self-administered anti-cancer prescription medication claims at a copayment/coinsurance level that is no less favorable than that for intravenous or injected anti-cancer medication prescribed for the same purpose and covered under employer's Cigna HealthCare plan. This assumption is applicable only if: (a) employer has contracted with a PBM (not Cigna HealthCare); (b) employer's plan is either insured, or, if self-funded, not subject to ERISA (i.e., is a church, government or association plan); and (c) employer's Cigna HealthCare plan is situsedin IA, HI, NM, OR, NJ, NE, VA, MA, NV, FL, ME, GA or a state with similar chemotherapy coverage law, or covers one or more individuals residing in CO, OK, VT, WA, TX, LA, MO, OH or in a state with similar extraterritorial chemotherapy coverage mandate.

- does not apply to individuals unless employed by the policyholder or an entity that participates in an association or trust that is the policyholder.

- assumes that any non-voluntary vision benefit that is included in the medical plan and not provided through a separate policy is subject to ACA requirements.

- includes Cigna's One Guide digital and customer guidance solution.

For CIGNA HealthCare of Arizona, Inc. and Cigna Health & Life Insurance Company (CHLIC) insured group plans, groups that have at least 12,000 member months in their claims experience period and a minimum of six consecutive months of claims experience are rated using adjusted community rating (ACR), which applies full credibility to group specific medical claims experience. Groups between 600 and 12,000 member months in their claims experience period and a minimum of six consecutive months of claims experience are rated based upon a meld of ACR and CRC. Groups with more than 50 employees and less than 600 member months in their claims experience period are rated using CRC.

Important Notice Regarding Benefit Advisor Compensation - The premium for this Shared Returns policy may not include compensation payable to your benefit advisor. Check with your Cigna Sales representative to confirm whether this is the case. When that is the case, the proposed billed amount includes both premium and benefit advisor fees, which are not part of the monthly premium and Cigna will include any benefit advisor fees agreed to by the client and benefit advisor on client invoices and forward payments received to the benefit advisor if both the client and the benefit advisor authorize Cigna to do so by signing Cigna's Client and Benefit Advisor Acknowledgement Form. When required, this form must be signed before the date when the new rates take effect. If the form is not signed, the benefit advisor will be responsible for billing the client directly for any benefit advisor fees.

C. Additional Representations & Disclosures

The plans presented in this proposal have an actuarial value, determined by Cigna HealthCare, of 60% or greater. This determination was made using Cigna HealthCare's manual rating application which may produce an actuarial value slightly different than the official HHS calculator. Although we would expect any deviation to be small, you will have to consult with your actuarial consultant for a more precise determination of the plan's actuarial value. Cigna HealthCare does not provide actuarial certifications.

Cigna Healthcare may pay on your behalf any applicable state tax or assessment imposed upon your plan by drawing upon the bank account.

In order to implement the requested benefit design, different funding arrangements (i.e., insured, self-insured and/or HMO) involving affiliated Cigna companies may be required with respect to plan participants residing in certain states.

Cigna HealthCare may have an agreement with your benefit advisor, under which the benefit advisor may be paid for providing marketplace intelligence or for the performance of administrative services. The qualification for and amount of this payment may be based upon overall business growth and/or retention levels. Any such payment is funded through Cigna HealthCare's general overhead.

The benefit advisor may qualify for incentive payment (monetary or non-monetary) from Cigna HealthCare. For example, the benefit advisor may receive payment based upon new sales, new customer growth or retention. This incentive payment is funded from Cigna HealthCare's general overhead.

Cigna HealthCare sponsors programs to inform benefit advisors about Cigna HealthCare's plan coverage and services (including producer advisory councils). The cost of these events is funded through Cigna HealthCare's general overhead.

Includes Fixed Charges for Embarc Benefit Protection[SM], a network solution for certain high-cost gene therapy drugs arranged by eviCore.

Cigna HealthCare reserves the right to change the Quoted Rates and/or Quoted Benefits or to decline to offer coverage if any of the foregoing information is inaccurate or changes prior to the proposed Effective Date indicated above, or if the quoted rates and/or fees are not agreed to within 60 days of receipt of this summary information form. If any of the information identified above changes either prior to the proposed Effective Date or while coverage is in effect, you agree to notify us promptly of such change.

The "Underwriting Contingencies" set forth above shall survive execution of any insurance policy, application, etc., issued by Cigna HealthCare or any affiliated company, and shall further survive the effective date of any such policies.

Cigna will administer the Insured Fully Insured Plus (i.e.,experience-rated) policy which is the subject of this proposal as explained below.

Experience-rating is the process by which the Cigna underwriter establishes the premium rate for the upcoming policy period using the claim and expense experience of the previous policy period. Due to the fact that the policyholder participates in the risk through the experience-rating process, experience-rated policies are also referred to as "participating." Cigna contracts covering the same group will be treated as a single experience program for experience-rating purposes. (This may include contracts issued by affiliated Cigna companies such as HMOs)

Following the end of a policy period (typically a 12 month period), the Cigna underwriter completes a settlement for that policy period to determine whether there is a Margin or a Deficit. "Margin" means any excess of premium over claim payments, changes in reserve liability, premium taxes, claim handling and any administrative expenses. "Deficit" means the excess of claim payments, including changes in reserve liability, premium taxes, claim handling and any administrative expense over premium. Administrative expenses will be applied in the settlement calculation using the guaranteed expense percentage reflected in the terms and conditions section of the financial proposal. Access fees and pooled premium and claims are excluded from the settlement calculation.

If the policy period experience produces a Margin, a dividend credit equal to 50% of the Margin amount will be granted to the policyholder, provided the policy is renewed for the subsequent policy year and the policy is in effect at the time the settlement is reported to the policyholder.. The credit may be in the form of a return of premium for the prior policy period, a reduction in the premium that would otherwise be charged for the next policy, or both. The margin can also be placed in a "Premium Stabilization Reserve" or "PSR" and used to offset future premium charges.

Margins accumulate interest at an annual rate established by Cigna. Margins credited to a PSR by Cigna are credited with interest until the funds are used for the payment of policy premium and/or the PSR is terminated. Interest charges/credits are incorporated when setting the administrative expense component of the rates.

Summary of the Insured Fully Insured Plus experience-rated provision:

- Following the end of the policy period, the Cigna underwriter will complete a settlement to determine whether the policy year ended in a Margin or Deficit.
- Margins result in a credit to the policyholder of 50% of the Margin amount, provided the policy is renewed in the subsequent policy year and the policy is in effect at the time the settlement is reported to the policyholder.
- If a Deficit occurs, the Deficit amount will not be recovered from prior policy year Margins nor will be carried forward to be recovered from future policy year Margins.

If you have any questions regarding the administration of the experience-rating process, please contact your Cigna Sales Representative immediately. If you do not notify us of any objection to the administration described within 30 days of receipt of this explanation, you will be deemed to have agreed to the administration described once the Shared Returns policy is effective.

June 18, 2024
City of Coral Gables
2151 Salzedo Street, Suite 520
Coral Gables, FL 33134

RE: City of Coral Gables EAP Renewal

Evernorth Behavioral Health, Inc. ("Evernorth Behavioral"), formerly known as Cigna Behavioral Health, Inc. and City of Coral Gables have partnered together for a successful Employee Assistance Program ("EAP"). We are pleased to continue providing this program to City of Coral Gables and we appreciate this opportunity to continue working with you.

Employee Assistance Program

The below EAP renewal information is for the 60-month period beginning 1/1/2025 through 12/31/2029.

Rates/Fees

Product	*Current Fee	*Renewal Fee	Rate Change	Employer Service Hours
Emp. Asst. & LE A&R 1/1/2025 – 12/31/2026	$1.30 PEPM*	$1.30 PEPM*	0.00%	5 hours per 1,000 employees or 3 actual hours per contract year
Emp. Asst. & LE A&R 1/1/2027– 12/31/2028	$1.30 PEPM*	$1.34 PEPM*	3.00%	5 hours per 1,000 employees or 3 actual hours per contract year
Emp. Asst. & LE A&R 1/1/2029– 12/31/2029	$1.34 PEPM*	$1.38 PEPM*	3.00%	5 hours per 1,000 employees or 3 actual hours per contract year

**per employee per month*

The above rate represents a blended EAP rate which is lower than the standard full-service EAP rate, due to enrollment in Cigna Total Behavioral Health ("CTBH") for a portion of the covered employee population.

Evernorth Behavioral will not revise the EAP rate during the 24 period from the renewal date, assuming all other financial assumptions remain constant. It assumes an employee count of 512 and includes 3 employer service hours per contract year to be used for critical incident responses, manager training, and on-site wellness seminars. Should you exceed 3 employer service hours per 12-month period, you may purchase additional hours on a fee-for-service basis.

This renewal for your EAP continues to provide three (3) face-to-face visits per presenting issue at no charge to all employees and their household members, management consultation and referral services. Evernorth Behavioral will continue to provide EAP services for City of Coral Gables pursuant to the terms of your EAP agreement ("Agreement"). This signed renewal letter will serve to amend the Agreement. Please have a duly authorized individual of City of Coral Gables sign to indicate acceptance of the above rate.

Retain a copy of the renewal letter for your files and return the signed original to me at the following address:

Cigna

Attn: Dina D'Angelo

By email: dina.dangelo@cigna.com

If a signature is not obtained within thirty (30) days prior to the effective date of this renewal notice, the renewal terms will be deemed accepted as presented. The renewal letter and receipt confirmation will serve as the contract amendment. Evernorth Behavioral will continue to provide services for participants pursuant to the terms of the Agreement, as amended.

If you have any questions about the information in this letter, please contact me at 954.790.8152 as soon as possible.

Thank you for the opportunity to continue to serve you and your employees.

Best regards,

Dina D'Angelo, Senior Client Manager

Cc: Lisa McDonald, Behavioral Account SME

Accepted by: _____ Title: _____

Date: _____

Additional Pricing

There is no additional pricing. Everything we proposed in the medical proposal is included in the rates.

EXHIBIT H
PROPOSED BENEFITS
RESPONSE FORM

Response Form - Medical Insurance - Proposed Benefits
The City is interested in a program that matches to the utmost extent possible, the City of Coral Gables' current plan design. In addition to offering up to two alternative plan options. Plan designs shall include; HMO and PPO plan options. Plan benefit, deductibles and copays must remain unchanged for a minimum of 12 months.

Please illustrate how your company's proposed benefits would compare to the current. This comparison is to be included in your RFP response.

Carrier: Cigna _____

Current - Cigna OAPIN HMO Base Plan

Schedule of Benefits	Current Plan - In Network	Proposed Plan - In Network
Network(s) Utilized	Open Access	Open Access
Deductible - Plan Year or Calendar Year	Calendar Year	Calendar Year
Employee Deductible	$0	$0
Employee + Family Deductible	$0	$0
Out-of-Pocket Maximum Employee	$6,250	$6,250
Out-of-Pocket Maximum Employee + Family	$12,500	$12,500
Member Coinsurance	0%	0%
Physician Office Visit	$20 Copay	$20 Copay
Specialist Office Visit	$30 copay	$30 copay
Preventive Care	No Charge	No Charge
Telehealth / Virtual Visit	$20 copay	$20 copay
Independent Clinical Lab	No Charge	No Charge
X-rays	No Charge	No Charge
Advanced Imaging (MRI, PET, CT)	No Charge	No Charge

Urgent Care Visit	$30 Copay	$30 Copay
Outpatient Surgery in Surgical Center	$300 copay	$300 copay
Physician Services at Surgical Center	No Charge	No Charge
Inpatient Hospital (Per Admit)	$500/Day (3 Days max)	$500/Day (3 Days max)
Outpatient Hospital (Per Visit)	$300 copay	$300 copay
Physician Services at Hospital	No Charge	No Charge
Emergency Room (Per Visit)	$100 copay	$100 copay
Mental Health & Substance Abuse Inpatient Hospital (Per Admit)	$500/Day (3 Days Max)	$500/Day (3 Days Max)
Mental Health & Substance Abuse Outpatient Services (Per Visit)	No Charge	No Charge
Mental Health & Substance Abuse Office Visit	$30 copay	$30 copay
Prescription Drugs - Tier 1 / Generic	$15 Copay	$15 Copay
Prescription Drugs - Tier 2 / Preferred Brand Name	$30 Copay	$30 Copay
Prescription Drugs - Tier 3 / Non-Preferred Brand Name	$55 copay	$55 copay
Prescription Drugs - Tier 4 / Specialty Drugs	25%	25%
Prescription Drugs - 90-day supply Mail Order	2.5x Retail	2.5x Retail

Please provide the monthly rates for the proposed line of coverage.

Coverage Tiers	Current Rates	Proposed Rates
Employee Only	$1,096.86	1,128.67
Employee Spouse	$1,895.37	1,950.34
Employee Child(ren)	$1,715.51	1,765.26
Employee Family	$2,232.11	2,296.84

Please fill out this table if you are providing a quote for a medical plan with In-Network Benefits.

Current - Cigna OAPIN HMO Buy-Up Plan

Schedule of Benefits	Current Plan - In Network	Proposed Plan - In Network
Network(s) Utilized	Open Access	Open Access
Deductible - Plan Year or Calendar Year	Calendar Year	Calendar Year
Employee Deductible	$0	$0
Employee + Family Deductible	$0	$0
Out-of-Pocket Maximum Employee	$3,500	$3,500
Out-of-Pocket Maximum Employee + Family	$7,000	$7,000
Member Coinsurance	0%	0%
Physician Office Visit	$30 Copay	$30 Copay
Specialist Office Visit	$45 copay	$45 copay

Preventive Care	No Charge	No Charge
Telehealth / Virtual Visit	$30 copay	$30 copay
Independent Clinical Lab	No Charge	No Charge
X-rays	No Charge	No Charge
Advanced Imaging (MRI, PET, CT)	No Charge	No Charge
Urgent Care Visit	$75 Copay	$75 Copay
Outpatient Surgery in Surgical Center	$250 copay	$250 copay
Physician Services at Surgical Center	No Charge	No Charge
Inpatient Hospital (Per Admit)	$250 copay	$250 copay
Outpatient Hospital (Per Visit)	$250 copay	$250 copay
Physician Services at Hospital	No Charge	No Charge
Emergency Room (Per Visit)	$150 copay	$150 copay
Mental Health & Substance Abuse Inpatient Hospital (Per Admit)	$250 copay	$250 copay
Mental Health & Substance Abuse Outpatient Services (Per Visit)	No Charge	No Charge
Mental Health & Substance Abuse Office Visit	$45 copay	$45 copay
Prescription Drugs - Tier 1 / Generic	$15 Copay	$15 Copay
Prescription Drugs - Tier 2 / Preferred Brand Name	$30 Copay	$30 Copay
Prescription Drugs - Tier 3 / Non-Preferred Brand Name	$55 copay	$55 copay

Prescription Drugs - Tier 4 / Specialty Drugs	25%	25%
Prescription Drugs - 90-day supply Mail Order	2.5x Retail	2.5x Retail

Please provide the monthly rates for the proposed line of coverage.

Coverage Tiers	Current Rates	Proposed Rates
Employee Only	$1,293.75	1,331.27
Employee Spouse	$2,235.60	2,300.43
Employee Child(ren)	$1,957.31	2,014.07
Employee Family	$2,632.77	2,709.12

Please fill out this table if you are providing a quote for a medical plan with In-Network and Out-of-Network Benefits.

Current - Cigna OAP PPO Plan

Schedule of Benefits	Current Plan - In Network	Current Plan - Out of Network	Proposed Plan - In Network	Proposed Plan - Out of Network
Network(s) Utilized	Open Access	Open Access	Open Access	Open Access
Deductible - Plan Year or Calendar Year	Calendar Year	Calendar Year	Calendar Year	Calendar Year
Individual Deductible	$500	$1,500	$500	$1,500
Family Deductible	$1,000	$3,000	$1,000	$3,000
Out-of-Pocket Maximum Individual	$4,500	$9,000	$4,500	$9,000
Out-of-Pocket Maximum Family	$9,000	$18,000	$9,000	$18,000
Member Coinsurance	10%	40%	10%	40%
Physician Office Visit Copay	$30 Copay	40% after CYD	$30 Copay	40% after CYD

Preventive Care Copay	No charge	40%	No charge	40%
Telehealth / Virtual Visit	$30 Copay	Not Covered	$30 Copay	Not Covered
Specialist Office Visit Copay	$45 Copay	40% after CYD	$45 Copay	40% after CYD
Independent Clinical Lab	No Charge	40% after CYD	No Charge	40% after CYD
X-rays	No Charge	40% after CYD	No Charge	40% after CYD
Advanced Imaging (MRI, PET, CT)	No Charge after CYD	40% after CYD	No Charge after CYD	40% after CYD
Urgent Care Visit	$75 Copay	40% after CYD	$75 Copay	40% after CYD
Outpatient Surgery in Surgical Center	$250 Copay after CYD	40% after CYD	$250 Copay after CYD	40% after CYD
Physician Services at Surgical Center	10% after CYD	40% after CYD	10% after CYD	40% after CYD
Inpatient Hospital (Per Admit)	$500 Copay after CYD	40% after CYD	$500 Copay after CYD	40% after CYD
Outpatient Hospital (Per Visit)	$250 Copay after CYD	40% after CYD	$250 Copay after CYD	40% after CYD
Physician Services at Hospital	10% after CYD	30% after CYD	10% after CYD	30% after CYD
Emergency Room (Per Visit)	$150 copay	$150 Copay	$150 copay	$150 copay
Mental Health & Substance Abuse Inpatient Hospital (Per Admit)	$500 Copay after CYD	40% after CYD	$500 Copay after CYD	40% after CYD
Mental Health & Substance Abuse Outpatient Services (Per Visit)	No Charge after CYD	40% after CYD	No Charge after CYD	40% after CYD
Mental Health & Substance Abuse Office Visit	$45 Copay	40% after CYD	$45 Copay	40% after CYD
Tier 1 - Generic (30 day)	$15 Copay	50%	$15 Copay	50%
Tier 2 - Preferred Brand (30 day)	$35 Copay	50%	$35 Copay	50%

Tier 3 - Non-Preferred Brand (30 day)	$55 copay	50%	$55 Copay	50%
Prescription Drugs - Tier 4 / Specialty Drugs	25%	50%	25%	50%
Mail Order 90 Day Supply	2.5x Retail	50%	2.5x Retail	50%

Please provide the monthly rates for the proposed line of coverage.

Coverage Tiers	Current Rates	Proposed Rates
Employee Only	$1,453.78	1,495.94
Employee + Spouse	$2,512.13	2,584.98
Employee + Child(ren)	$2,274.83	2,340.80
Employee + Family	$2,958.42	3,044.21

Below is the Alternate HMO Base Plan Response Form-1.

Schedule of Benefits	Current Plan - In Network	Proposed Plan - In Network
Network(s) Utilized	Open Access	Open Access
Deductible - Plan Year or Calendar Year	Calendar Year	Calendar Year
Employee Deductible	$500	$500
Employee + Family Deductible	$1,000	$1,000
Out-of-Pocket Maximum Employee	$6,250	$6,250
Out-of-Pocket Maximum Employee + Family	$12,500	$12,500
Member Coinsurance	10%	10%
Physician Office Visit	$20 Copay	$20 Copay
Specialist Office Visit	$30 copay	$30 copay

Preventive Care	No Charge	No Charge
Telehealth / Virtual Visit	$20 copay	$20 copay
Independent Clinical Lab	No Charge	No Charge
X-rays	No Charge	No Charge
Advanced Imaging (MRI, PET, CT)	No charge	No Charge
Urgent Care Visit	$30 Copay	$30 Copay
Outpatient Surgery in Surgical Center	$300 copay	$300 copay
Physician Services at Surgical Center	No Charge	No Charge
Inpatient Hospital (Per Admit)	$500/Day (3 Days Max)	$500/Day (3 Days Max)
Outpatient Hospital (Per Visit)	$300 copay	$300 copay
Physician Services at Hospital	No Charge	No Charge
Emergency Room (Per Visit)	$100 copay	$100 copay
Mental Health & Substance Abuse Inpatient Hospital (Per Admit)	$500/Day (3 Days Max)	$500/Day (3 Days Max)
Mental Health & Substance Abuse Outpatient Services (Per Visit)	No Charge	No Charge
Mental Health & Substance Abuse Office Visit	$30	$30
Prescription Drugs - Tier 1 / Generic	$15 Copay	$15 Copay
Prescription Drugs - Tier 2 / Preferred Brand Name	$30 Copay	$30 Copay
Prescription Drugs - Tier 3 / Non-Preferred Brand Name	$55 copay	$55 copay

Prescription Drugs - Tier 4 / Specialty Drugs	25%	25%
Prescription Drugs - 90-day supply Mail Order	2.5x Retail	2.5x Retail

Please provide the monthly rates for the proposed line of coverage.

Coverage Tiers	**Proposed Rates**
Employee Only	$1,104.45
Employee + Spouse	1,908.49
Employee + Child(ren)	1,727.38
Employee + Family	2,247.56

Below is the Alternate HMO Base Plan Response Form -2.

Schedule of Benefits	**Current Plan - In Network**	**Proposed Plan - In Network**
Network(s) Utilized	Open Access	Open Access
Deductible - Plan Year or Calendar Year	Calendar Year	Calendar Year
Employee Deductible	$1,500	$1,500
Employee + Family Deductible	$3,000	$3,000
Out-of-Pocket Maximum Employee	$8,000	$8,000
Out-of-Pocket Maximum Employee + Family	$10,000	$10,000
Member Coinsurance	10%	10%
Physician Office Visit	$30 Copay	$30 Copay
Specialist Office Visit	$45 copay	$45 copay

Preventive Care	No Charge	No Charge
Telehealth / Virtual Visit	$30 copay	$30 copay
Independent Clinical Lab	No charge	No charge
X-rays	No charge	No charge
Advanced Imaging (MRI, PET, CT)	10% after CYD	10% after CYD
Urgent Care Visit	$50 copay	$50 copay
Outpatient Surgery in Surgical Center	$1000 copay	$500 – same as OP Hospital
Physician Services at Surgical Center	$500 copay	$500 copay
Inpatient Hospital (Per Admit)	$500/per day – 3 day max	$500/per day – 3 day max
Outpatient Hospital (Per Visit)	$500 copay	$500 copay
Physician Services at Hospital	$250 copay	Cannot separate
Emergency Room (Per Visit)	$200 copay	$200 copay
Mental Health & Substance Abuse Inpatient Hospital (Per Admit)	$500/per day – 3 day max	$500/per day – 3 day max
Mental Health & Substance Abuse Outpatient Services (Per Visit)	No Charge	No Charge
Mental Health & Substance Abuse Office Visit	No Charge	No Charge
Prescription Drugs - Tier 1 / Generic	$15 Copay	$15 Copay
Prescription Drugs - Tier 2 / Preferred Brand Name	$35 Copay	$35 Copay
Prescription Drugs - Tier 3 / Non-Preferred Brand Name	$55 copay	$55 copay

Prescription Drugs - Tier 4 / Specialty Drugs	25%	25%
Prescription Drugs - 90-day supply Mail Order	2.5x Retail	2.5x Retail

Please provide the monthly rates for the proposed line of coverage.

Coverage Tiers	**Proposed Rates**
Employee Only	1,045.14
Employee + Spouse	1,806.00
Employee + Child(ren)	1,634.62
Employee + Family	2,126.87

Below is the EAP Response Form

Employee Assistance Program	**Current Plan -Evernorth Behavioral Health, Inc.**	**Proposed EAP Plan**
Number of Face-to-Face Sessions Per Year	Up to 3 per year, per issue	Up to 3 per year, per issue
Eligibility	All Household members	All Household members
Counseling & Relationship Support	Unlimited, toll-free telephonic access 24/7	Unlimited, toll-free telephonic access 24/7
Online Resources (Research, Topics & Support)	Unlimited Access	Unlimited Access
Relationship Issues	Included	Included
Substance Abuse	Included	Included
Marital Problems	Included	Included
Work/Life Balance	Included	Included
Child & Senior Care	Included	Included

Stress Management	Included	Included
Legal & Financial Services	Included	Included
Identity Theft Consultation	Included	Included
Manager & Supervisor Training	Combined Pool of 3 Employer Service Hours or 5 hours per/1,000 EEs per contract year	Combined Pool of 3 Employer Service Hours or 5 hours per/1,000 EEs per contract year
Initial Orientation Sessions	Combined Pool of 3 Employer Service Hours or 5 hours per/1,000 EEs per contract year	Combined Pool of 3 Employer Service Hours or 5 hours per/1,000 EEs per contract year
Employee Seminars	Combined Pool of 3 Employer Service Hours or 5 hours per/1,000 EEs per contract year	Combined Pool of 3 Employer Service Hours or 5 hours per/1,000 EEs per contract year
Critical Incident Debriefing	Combined Pool of 3 Employer Service Hours or 5 hours per/1,000 EEs per contract year	Combined Pool of 3 Employer Service Hours or 5 hours per/1,000 EEs per contract year
Brochures & Workplace Posters	Included	Included
Comprehensive Reporting	Included	Included
Rate Guarantee	12/31/20258	12/31/2029
Rate PEPM	**$1.30**	**$1.30**

EXHIBIT I

PERFORMANCE STANDARDS/GUARANTEES

City of Coral Gables Performance

Standards / Guarantees

Exhibit G

Performance Guarantees	Cost of Non-Performance	Deviations
Eligibility Turnaround – All employee enrollment files will be updated within the carrier's system within 5 days of receipt from the City of Coral Gables.	$500 per day	Cigna calculates penalties at a flat $ per contract year and is willing to work with the City on the metric.
ID Cards - Both at implementation and annually within two (2) weeks following the date City of Coral Gables provides enrollment data to the vendor, ID cards must be delivered to the member's home address.	$25 per card for each day beyond two (2) weeks following the date enrollment data is sent by City of Coral Gables.	ID Cards Maintenance results will meet: 100% mailed within 5 Business Days after the release of, not receipt of, clean and accurate eligibility to the ID card vendor. Implementation ID Card Timeliness. 98% of the ID cards will be mailed by the agreed upon Commitment Date in the Implementation Calendar. Cigna calculates penalties at a flat $ per contract year and is willing to work with the City on the metric.
Claims Adjudication – All health claims must be processed within 30 days of receipt.	$500 per occurrence	90% of Claims Processed within 14 calendar days 98% of Claims Processed within 30 calendar days. Cigna calculates penalties at a flat $ per contract year and is willing to work with the City on the metric.
Brochures/descriptive literature must be delivered to City of Coral Gables, or to its designees as directed, in final form within 30 calendar days prior to open enrollment. Additional materials must be provided within 30 calendar days of a request by the Benefits staff.	$500 per day	Cigna calculates penalties at a flat $ per contract year and is willing to work with the City on the metric.
All **written inquiries** or complaints by Benefits staff or plan participants must have a written response from the Proposer within 30 calendar days.	$500 per occurrence	Cigna calculates penalties at a flat $ per contract year and is willing to work with the City on the metric.

Any letters sent to plan participants by health care providers threatening legal action, referral to a collection agency or other negative action must be responded to directly by the Proposer within five calendar days of receipt of such correspondence by the Proposer.	$500 per occurrence	Cigna does not offer a PG metric around response to negative action letters from providers as there is no process to measure response time.
Monthly Paid Claim Reporting will be provided to the City of Coral Gables and their Consultants by the 5th day of each month.	$100 per day	Cigna calculates penalties at a flat $ per contract year and is willing to work with the City on the metric.
Annual Renewal Presentation – The renewal of the health insurance program will be delivered to the City's Consultants by June 1.	$100 per day	Cigna calculates penalties at a flat $ per contract year and is willing to work with the City on the metric.

***Please see PG Client document included for further details and additional offered metrics.**

Performance Guarantees
City of Coral Gables
Effective Start Date: January 1, 2025

IMPLEMENTATION

Identification Card Delivery Implementation ID Card Timeliness. 98% of the ID cards will be mailed by the agreed upon Commitment Date in the Implementation Calendar. Results measured at Account Level.	Amount At Risk $1,000.00
Claim Readiness Implementation Claim Readiness. Benefit Profile and eligibility information loaded on claims processing system as of the Commitment Date set forth in the approved Implementation Calendar. Results measured at Account Level.	Amount At Risk $1,000.00
Call Readiness Implementation Call Readiness. Service Center(s) ready to respond to customer inquiries as of the Commitment Date set forth in the approved Implementation Calendar. Results measured at Account Level.	Amount At Risk $1,000.00
Implementation Satisfaction Implementation Satisfaction. Score of no less than three (3) on the question: Overall, how satisfied were you with your most recent installation experience with Cigna? in the Cigna HealthCare Implementation Survey. Results measured at Account Level.	Amount At Risk $1,000.00

SERVICE

Claim Time-to-Process Medical Time to Process. Measured for the Term of the Agreement, results will meet or exceed: 90% of Claims Processed within 14 calendar days. Results measured at Account Level.	Amount At Risk $1,000.00
Claim Time-to-Process Medical Time to Process. Measured for the Term of the Agreement, results will meet or exceed: 98% of Claims Processed within 30 calendar days. Results measured at Account Level.	Amount At Risk $1,000.00
Average Speed of Answer Medical ASA. Measured for the Term of the Agreement, results will not exceed: 45 seconds to answer a phone call. Results measured at Special Account Queue Level.	Amount At Risk $1,000.00
Call Abandonment Rate Medical Call Abandonment Rate. Measured for the Term of the Agreement, results will not exceed: 3% of calls received by Call Center(s) terminated. Results measured at Special Account Queue Level.	Amount At Risk $1,000.00
Automated Maintenance Eligibility Processing Medical Auto Eligibility Processing. Measured for the Term of the Agreement, results will meet or exceed: 100% files processed in 5 Business Days after the receipt of clean eligibility. Results measured at Account Level.	Amount At Risk $1,000.00
ID Card Maintenance Combined (Medical/Dental) ID Cards Maintenance. Measured for the Term of the Agreement, results will meet: 100% mailed within 5 Business Days after the release of, not receipt of, clean and accurate eligibility to the ID card vendor. Results measured at Account Level.	Amount At Risk $1,000.00

SERVICE

Account Management Other Service Metric 1. Brochures/descriptive literature must be delivered to City of Coral Gables, or to its designees as directed, in final form within 30 calendar days prior to open enrollment. Additional materials must be provided within 30 calendar days of a request by the Benefits staff.	Amount At Risk $1,000.00
Account Management Other Service Metric 2. All written inquiries or complaints by Benefits staff or plan participants must have a written response from the Proposer within 30 calendar days.	Amount At Risk $1,000.00
Account Management Other Service Metric 4. Annual Renewal Presentation – The renewal of the health insurance program will be delivered to the City's Consultants by June 1.	Amount At Risk $1,000.00
Reporting Other Service Metric 3. Monthly Paid Claim Reporting will be provided to the City of Coral Gables and their Consultants by 10 business days after the end of each month.	Amount At Risk $1,000.00

Cigna has no exceptions to the RFP provisions. We have provided clarifying responses to certain RFP provisions below.

SECTION 1 – INTRODUCTION TO REQUEST FOR PROPOSAL

1.6 Agreement Execution

By submitting a Response, the Proposer agrees to be bound to and execute the Agreement for this solicitation. Without diminishing the foregoing, the Proposer may request clarification and submit comments concerning the Agreement for City's consideration. Only comments and proposed revisions included within the Response will be considered by the City. Any comments identified after the Response has been received may not be considered by the City. Furthermore, any requests to negotiate provisions of the Agreement not identified in the Response after the Response has been received, may be grounds for removal from further consideration for award. None of the foregoing shall preclude the City from seeking to negotiate changes to the Agreement during the negotiations process.

Failure of the Successful Proposer to execute a contract within thirty (30) days after the notification of award may, at the City's sole discretion, constitute a default. However, the Agreement must be executed no later than one hundred twenty (120) days, based upon the requirements set forth in the RFP through action taken by the City Commission at a duly authorized meeting. If the Proposer first awarded the Agreement fails to enter into the contract as herein provided, the award may be declared null and void, and the Agreement awarded to the next most responsible, responsive Proposer, or re-advertised, as determined by the City.

Cigna agrees to work in good faith with the City to negotiate the submitted sample agreement, or any other agreement, to be agreeable to the Parties.

Specific to the Business Associate Agreement (BAA), under a fully insured arrangement, HIPAA privacy and security rules do not require us to enter into a BAA, as Cigna is the insurer and the covered entity, not the group health plan's (client) business associate. Member privacy and confidentiality will be protected in accordance with HIPAA/HITECH privacy regulations.

SECTION 4 – GENERAL CONDITIONS

4.2 Legal Requirements

The Proposer shall comply with all rules, regulations and laws of the City of Coral Gables, Miami-Dade County, the State of Florida and the Federal Government now in force or hereinafter to be adopted. Lack of knowledge by the Proposer shall in no way be cause for relief from responsibility.

Cigna complies with federal laws, regulatory requirements, as well as state laws to the extent that provisions of federal laws that are applicable to our services do not preempt them.

4.12 Sub-Contractor

A Sub-Contractor / Sub-Consultant is an individual or firm contracted by the Proposer(s) to assist in the performance of services required under this RFP. A Sub-Contractor / Sub-Consultant shall be paid through Proposer(s) and not paid directly by the City. Sub-Contractors / Sub-Consultants are allowed by the City in the performance of the services delineated within this RFP. Proposer(s) shall clearly reflect in its Response the major Sub-Contractor / Sub-Consultant to be utilized in the performance of required services. The City retains the right to accept or reject any Sub-Contractor / Sub-Consultant proposed prior to Agreement execution. Any and all liabilities regarding the use of a Sub-Contractor / Sub- Consultant shall be borne solely by the Successful Proposer(s) and insurance for each Sub-Contractor / Sub-Consultant must be maintained in good standing and approved by the City throughout the duration of the Agreement. Neither the Successful Proposer(s) nor any of its Sub-Contractors / Sub-Consultants are considered to be employees or agents of the City. Failure to list all major Sub-Contractors / Sub- Consultants and provide the required information may disqualify any proposed Sub-Contractor / Sub- Consultant from performing work under this RFP.

Proposer(s) shall include in their Responses the requested Sub-Contractor / Sub-Consultant information and include all relevant information required of the Proposer(s).

As the sole provider of services requested in this RFP, Cigna agrees not to assign the contract in whole and agrees to seek prior written consent of the City for any subcontract work procured specifically to provide the services requested in this proposal.

4.19 Auditing of Records

The successful Proposer’s book and records as they relate to the anticipated contract must be made available for inspection and audit upon receipt of three (3) days prior written notice from the City and remain available for City or other applicable sources for inspection for at least three (3) years following the expiration of the contract.

When required by applicable state or federal law and in keeping with the standards of the industry and Cigna's standard audit and review procedures, Cigna shall cooperate with a required audit or review of applicable documents conducted by a duly authorized representative. However, under a fully insured arrangement, Cigna is fully responsible for claims administration and carries all risk associated with such processes therefore, external audits are not permitted. Cigna has an internal claim quality assurance program to monitor internal performance standards to ensure the accuracy of claims payment.

SECTION 5 – INDEMNIFY, DEFEND AND HOLD HARMLESS & INSURANCE REQUIREMENTS

5.1 To the fullest extent permitted by Laws and Regulations, the Professional shall defend, indemnify, and hold harmless the City and its attorneys, administrators, consultants, elected and appointed officials, agents, and employees from and against all claims, damages, losses, and expenses direct, indirect, or consequential (including but not limited to fees and charges of attorneys and other professionals and court and arbitration costs) arising out of or resulting from the performance of the work and caused in whole or in part by any willful, intentional, reckless, or negligent act or

omission of Professional, any sub- consultant, or any person or organization directly or indirectly employed by any of them to perform or furnish any of the work or anyone for whose acts any of them may be liable.

In any and all claims against the City, its elected and appointed officials or any of its consultants, attorneys, administrators, agents, or employees by any employee of Professional, any sub-consultant, any person or organization directly or indirectly employed by any of them to perform or furnish any of the work or anyone for whose acts any of them may be liable, the indemnification obligation under the above paragraph shall not be limited in any way by any limitation on the amount or type of damages, compensation, or benefits payable by or for Professional or any such sub-consultant or other person or organization under workers' or workman's compensation acts, disability benefit acts, or other employee benefit acts. Moreover, nothing in this Indemnification and Hold Harmless provision shall be considered to increase or otherwise waive any limits of liability, or to waive any immunity, established by Florida Statutes, case law, or any other source of law.

Cigna will indemnify and hold the City, its officers, directors, agents, and/or employees (acting in the scope of their employment and not as claimants under the plan) harmless from and against all costs, damages, judgments, attorney fees, expenses, obligations, and liabilities of any kind or nature that occur as the result of Cigna's failure to pay valid claims within the terms and conditions of the policy where such failure is not due to any action or inaction by the City, its officers, directors, agents, and/or employees.

5.6.1 GENERAL CONDITIONS

Pursuant to the City of Coral Gables Code, Section 2-971, the Risk Management Division of the Office of Labor Relations and Risk Management has developed the following insurance requirements to protect the City of Coral Gables to the maximum extent feasible against any and all claims that could significantly affect the ability of the City to continue to fulfill it obligations and responsibilities to the taxpayers and the public.

Consequently, prior to award and in any event prior to commencing work, the Professional shall procure, and provide the City with evidence of insurance coverage as required herein and name the City as an Additional Insured on a primary and non-contributory basis. The Professional shall secure and maintain, at its own expense, and keep in effect during the full period of the contract a policy or policies of insurance and must submit these documents to the Risk Management Division of Human Resources and Risk Management Department.

Cigna is able to grant "additional insured" status to its clients and business partners on a blanket basis only. We provide also provide Certificate(s) of Insurance for the City's annual compliance verification.

SERVICE THAT SETS US APART

We've helped over 3 million[1] public sector members thrive.

Public sector employees are driven by a mission bigger than themselves. We offer services and solutions that put their unique needs first.

We're proud to sponsor the International City/County Management Association (ICMA) and National Forum for Black Public Administrators (NFBPA), two organizations that uniquely support the public sector and work with them to promote ways to improve the health and well-being of their membership and their communities.

Cigna has a national presence but also a local presence. We support communities across the country by supporting nonprofits addressing food insecurity, or organizations that deliver care to people who need it the most. In addition, our wellness initiatives help to drive positive outcomes for populations at risk for diseases such as diabetes and heart disease.

Local Government Business Model

There's no one-size-fits-all solution to manage costs and promote wellness. With our Cigna Smart Support® Program, created specifically for Government & Education clients, a dedicated team works with you to develop a specialized benefits plan focused on your needs. We then collaborate with you on implementation and employee support which can help them make more informed decisions, based on their personal needs and those of their families.

You get:

- Dedicated support across all business functions
- Tailored benefits strategy, focused on state- and population-specific needs
- Simplified implementation process for a seamless transition that meets your timeline

Your employees get:

- **Specialized service team** to help take control of their health and manage costs
- **24/7 service team** to get questions answered by live representatives
- **My Personal Champion® Program** for 1-on-1 help for employees dealing with complex medical care

A Commitment to Diversity, Equity and Inclusion

In 2020, we launched our Building Equity and Equality Program, a five-year initiative to expand and accelerate our efforts to support diversity, inclusion, equality and equity for communities of color.

Examples:

- In April 2021, we announced a partnership with Wake Forest School of Medicine to advance equity and equality among the next generation of doctors, nurses and health care workers.
- The Wake Forest partnership includes a $250,000 endowed scholarship to help support students of color as they **begin their medical studies.**

Cigna is committed to health equity and our Health Disparities Advisory Council (HDAC) highlights our client members and their initiatives to better serve people from underrepresented communities. We also get the Council's feedback on our programs to make sure we are addressing the right issues. The committee is also connected to their counterparts across the country to make sure all voices are represented.

Together, all the way.®

Cigna®

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Offered by Cigna Health and Life Insurance Company or its affiliates.

Unique behavioral needs

Behavioral health is a significant consideration for many people in the Local Government sector. Our data shows that one in five adults is dealing with a behavioral health issue.[2] The top behavioral health diagnoses for Government workers and their families include:[3]

Depression 26% • Alcohol use disorders 15% • Reactive stress disorders 13%

Our solutions benefit anyone in the Government & Education sector, but with our insights, we're able to deliver customized programs and support for first responders and educators in the K-12 space.

Grade-A benefits and behavioral health solutions for education.

We understand the challenges that school districts face, including attracting and retaining educators and staff while balancing budget constraints. We work with you to improve employee health – both body and mind.

Relevant resources

- Curated seminar series focusing on the needs of K-12 employees
- On-demand online resources
- Youth Mental Health First Aid: Training to help identify adolescents dealing with behavioral health or substance use issues

Tailored behavioral health services

- Employee Assistance Program (EAP)[4] focused on K-12
- Dedicated call center advocates who are trained to help our K-12 members
- Optional Critical Incident Stress Management program

Supporting Higher Ed

- $250,000 grant to the School of Education at Howard University
- 2019 sponsor of the University of Connecticut's partnership with Net Impact on a Supply Chain Sustainability MBA Case Competition
- Mental Health First Aid training

Specialized support for emergency responders

Mental Health Trainings

Awareness Seminar: In one hour, our licensed behavioral clinicians cover the stigma and prevalence of emotional health challenges.

Recognition and Response: A training that's under three hours and focuses on how to best respond to common emotional health challenges.

Mental Health First Aid Certification: An eight-hour, skills-based training with a curriculum developed by the National Council for Mental Wellbeing.

24/7 support

- Behavioral health crisis line
- Help finding in-network behavioral health providers
- Peer coaching, therapy and psychiatric support with providers who specialize in working with first responders

Tailored behavioral health services

Work with a specialized behavioral health provider who's certified by the National Emergency Responder and Public Safety Center. This certification helps providers understand and address the unique mental health needs of emergency responders.

Roundtable events

We connect responder leadership with local mental health community leaders for illuminating discussions about relevant topics.

Focused on thought leadership, Cigna has conducted studies and authored papers to help people better understand the impact of resilience, loneliness, COVID-19 and diversity, equity and inclusion. Ask your representative for copies.

See what sets Cigna apart in the public sector.

Reach out to your representative today. Or visit us online at **Cigna.com**.

1. Cigna Book of Business June 2021 2. 2020 Cigna Resilience Index Report 3. Cigna analysis of specialty medication users, integrated pharmacy and medical benefits claim review for Local Government Employers. Integrated Data Source Jan.–Dec. 2019. Results may vary. 4. Employee assistance program services are in addition to, not instead of, your health plan benefits. These services are separate from your health plan benefits and do not provide reimbursement for financial losses. Program availability may vary by plan type and location, and are not available where prohibited by law.

The Cigna Healthcare well-being solution, together with Virgin Pulse.

Package snapshots for quick comparison.

Cigna Healthcare℠ offers you and your employees access to a customized, highly engaging well-being solution powered by the digital health activation and engagement company, Virgin Pulse®.

Take a closer look at our package options — and discover how each one can drive engagement and help improve outcomes for your employees.

Core package

1,375+ Daily Content Cards: Improve well-being literacy and inspire new behaviors with micro-learning content

115+ Healthy Habits: AI-driven recommendations designed to reinforce healthy habits

Well-Being Challenges: Peer-to-peer challenges

Health Assessment: NCQA Certified Health Assessment including social determinants of health

Social Connections: Invite up to 10 friends and family to share in the experience

25+ Journeys®: Digital health coaching journeys ranging 10-24 days across topics

Device/App Connection: Connect any device, app or tracker that connects to Apple® Health app or Google Fit®

Core topics

- Getting Active
- Eating Healthy
- Sleeping Well
- Reducing Stress
- Finding Emotional Balance
- Coronavirus

Offered by Cigna Health and Life Insurance Company.

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Core plus package

Incentives & Rewards:
Specific actions can earn rewards within integrated designs that lead to ongoing engagement

2,800+ Daily Cards:
Improve well-being literacy and inspire new behaviors with micro-learning content

480+ Healthy Habits:
AI-driven recommendations designed to reinforce healthy habits

Digital Guides:
Sleep and nutrition tips, tricks, and tracking allowing personalized action plan

Well-Being Challenges:
Peer-to-peer challenges, monthly healthy habits challenges, 3 Cigna Healthcare challenges

Social Connections:
Invite up to 10 friends and family to share in the experience

60 Journeys:
Digital health coaching journeys ranging 10-24 days across topics

Device/App Connection:
Connect any device, app or tracker that connects to Apple® Health app or Google Fit®

My Care Checklist:
Preventive screening tracking and reminders that can be updated by the customer

29 digital topics:

- Acting Sustainably
- Alcohol Use
- Anxiety & Depression
- Back, Muscle & Joint Health
- Being Effective
- Being Productive
- Being Tobacco Free
- Blood Pressure
- Building Relationships
- Cholesterol
- Contributing to Community
- Coronavirus
- Diabetes
- Diversity, Equity & Inclusion
- Eating Healthy
- Finding Emotional Balance
- Getting Active
- Grief & Loss
- Heart Health
- Learning New Things
- Lung Health
- Managing My Finances
- Medicine Support
- Menopause
- Pregnancy
- Reducing Stress
- Sleeping Well
- Staying Safe
- Weight

Connected package

Option to purchase for all funding types

Customer experience

Includes everything in Core Plus **AND:**

- Client Logo
- Client-Specific Challenge

Client experience

- Includes two licenses to the administrative portal
- Live analytics of over 100 metrics across 8 domains, updated every 24 hours
- Ability to create custom content, including:

- Healthy Habits
- Announcements
- Daily Content Cards
- Analytics Dashboard
- Calendar Events
- Surveys

How are the three packages different?

While many features are included for all clients at no additional cost, there are additional opportunities to increase the content and resource options for a more complete user experience — and sustained employee engagement.

Rewards can be administered with the **Core Plus package.*** Employees can earn Pulse Cash® which can be redeemed for gift or debit cards, donations to charity, or for purchases in the Virgin Pulse store.

The **Connected package** provides clients with access to on-demand analytics of over 100 metrics, as well as the ability to create custom challenges, habits, announcements, calendars and surveys.

Features	Core	Core Plus	Connected
All packages offer health assessment, device/app integration and the opportunity to invite 10 friends and family.			
Daily Content Cards	1375+ cards across 6 topics	**2800+** cards across 29 digital topics	
Healthy Habits	115+ habits across 6 topics	**480+** healthy habits across 29 digital topics	
Digital Coaching Journeys	25+ across 6 topics	**60** journeys across 21 digital topics	
Well-Being Challenges	Peer to peer	• Peer to peer • **Monthly Virgin Pulse (VP) Healthy Habits** • **3 prescribed by Cigna Healthcare**	• Peer to peer • Monthly VP Healthy Habits • 3 prescribed by Cigna Healthcare • **1 client specific challenge** • **Ability to self admin challenge**
Rewards and Incentives*	**No**	**4** best-practices designs with pre-determined $ (or no incentives) **2-3** reward types (based on design selected)	
My Care Checklist	No	**X**	
Client Logo	No	No	**X**
Client Administrative Access	No	No	**X** **2 client licenses for admin access**

*Client funds incentive payout. Available upon sale/renewal with ready-to-services dates 4/1/2024 or later.

Contact your Cigna Healthcare representative to learn more.

To comply with federal laws, if an eligible employee is unable to participate in any of incentive program events, activities or goals due to a disability or other reason, they may be entitled to a reasonable accommodation for participation, or an alternative standard for rewards. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, contact a Cigna Healthcare representative.

An investment in your health.

Your Cigna Healthcare Health Improvement Fund.

There are many reasons to invest in an employee well-being program – healthier employees, improved productivity and lower medical costs.* Now, there's one more – a Health Improvement Fund. When using this fund, expenses should address your employees' whole health and meet your organization's health needs.

What is the intent of a Health Improvement Fund?

Eligible expenses must be offered and made generally available to all plan participants and be aligned with Cigna Healthcare℠ designated health and wellness improvement programs. Some examples include (but are not limited to) activities and challenges to promote healthy living, incentives for wellness program participation, fees associated with 5K race participation, subscription fees for wellness-related apps, guest speakers to present on health-related topics, onsite group exercise classes, etc.

How does it work?

The fund allotted to you in your Health Improvement Fund will be available to your organization throughout your current plan year or contract term. Any funds not used by the end of your plan year will be forfeited. **Health Improvement Fund approvals are subject to defined guidelines and usage in alignment with your Cigna Healthcare medical contract.**

Strategy

The Cigna Healthcare Account Team meets with you to personalize a health engagement strategy and review eligible expenses along with reimbursement submission format requirements.

Request Review

Discuss your expense requests with the Cigna Healthcare Account Team to determine eligibility before spending funds. Please note, if ineligible expenses are purchased, they will not be reimbursed.

Submit

Once confirmed, you make the purchase and submit the supporting invoice(s) and receipt(s) to the Cigna Healthcare Account Team. The invoice(s) or receipt(s) must clearly indicate proof of order or expenditure from the vendor providing the goods or services rendered.

Reimbursement

Cigna Healthcare will process and reimburse accordingly. Please allow 45–60 days for reimbursements to process.

cigna healthcare

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Category	Examples of Ineligible Expenses (including but not limited to the following):
Sponsorships	• Charity contributions • Sponsorships of golf tournaments, 5K races, county fairs, etc.
Capital Improvements** and Standard Operating Expenses***	• Office construction/redesign (e.g., renovations to a kitchen) • Safety ramps • HEPA filters • Furniture • Office real estate costs • Trainings required for day-to-day job responsibilities • Appliances (e.g., microwave, refrigerator, vending machine, beverage dispensers, etc.)
Gifts to individual employees or vendor staff	• Clothing/sporting equipment for subset of employees • Undocumented tips • Gifts for only certain employees (unrelated to incentive programs) • Gifts provided to all employees that are not tied to a wellness program
Medical claims and premium reductions	• Reimbursement for denied medical claims • Expenses for medical evaluations and immunizations not related to a specific wellness event • Premium reductions as incentive
Expenses for Cigna Healthcare employees	• Travel/airfare to Client Forum
Targeted events & related expenses	• Trainings only available to specific employees such as HR staff or leadership team members • Lunch provided during a targeted training session
Vendor/retail memberships	• Amazon Prime membership, Costco membership, shipping memberships, etc.
Prepayment requests	• Prepayment of fund expenses without receipts for charges
Social gatherings	• Picnics, team building, and/or employee appreciation events • Team-bonding events like sporting events, lunches, etc.
Open Enrollment incentives	• Open Enrollment giveaways
Communication unrelated to Wellness	• Payroll, open enrollment or benefits communication
COVID-19 expenses	• Cleaning supplies • Personal protective equipment • COVID-19 testing and/or vaccine clinic costs

For more information, contact your Cigna Healthcare Account Team.

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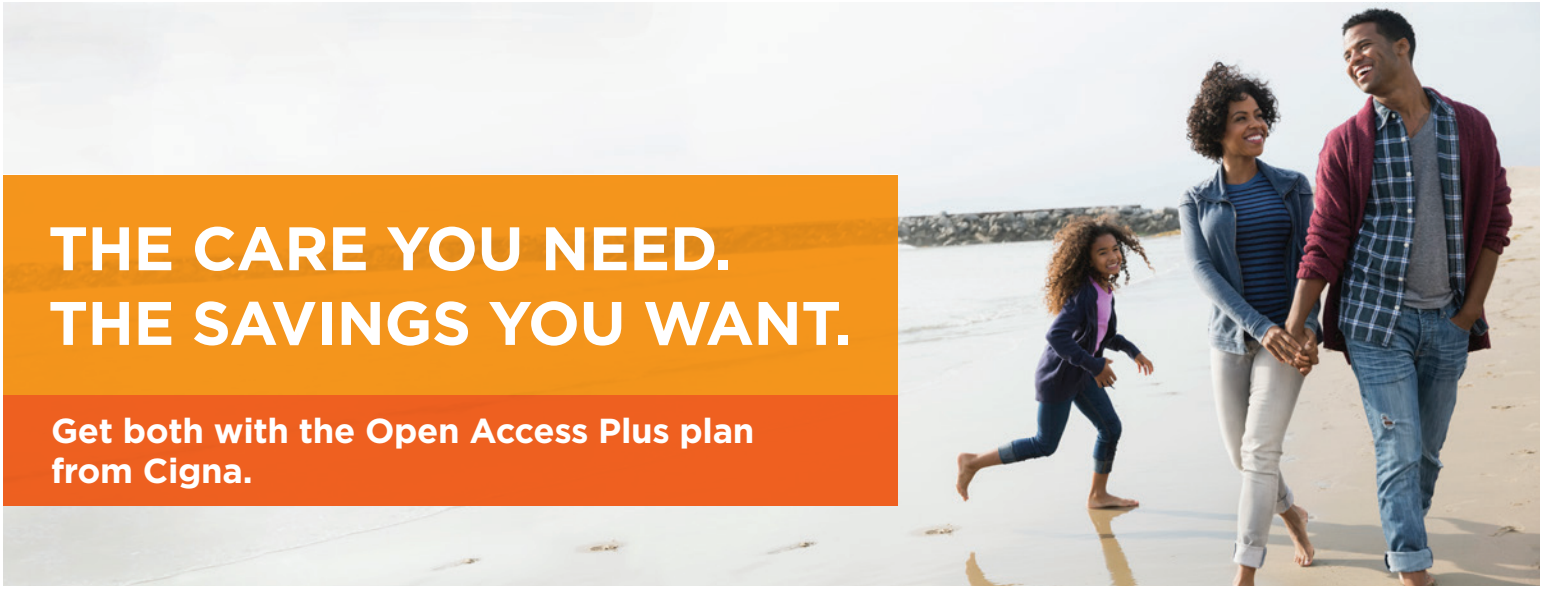
*The Employer Imperative, https://impact.economist.com/projects/healthy-workforce/report/, 2021

**Capital Improvements are defined as costs to buy, maintain, or improve an organization's fixed assets.

***Standard Operating Expenses are defined as costs to run a business that benefit an employer more than plan participants directly.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, contact a Cigna Healthcare representative.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (Bloomfield, CT), Evernorth Care Solutions, Inc., Evernorth Behavioral Health, Inc., and Express Scripts, Inc. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, contact a Cigna Healthcare representative.



THE CARE YOU NEED. THE SAVINGS YOU WANT.

Get both with the Open Access Plus plan from Cigna.

Offering flexible access to thousands of providers – plus programs and services to support your whole health needs – the Open Access Plus (OAP) plan is designed to make it easier for you to get the quality care you need and the savings you want.

Here's how it works.

- **In-network savings**
  You have the freedom to use any provider or facility of your choice, whether they are in the Cigna OAP network or out of the network. Just know that staying in-network will help keep your costs down and avoid any additional paperwork.
- **No-referral specialist care**
  A primary care provider (PCP) is recommended, but not required. If you need to see a specialist for any reason, you don't need a referral to see an in-network health care provider. If you choose an out-of-network specialist, your care will be covered at the out-of-network level and you may be responsible for any preauthorizations needed.
- **Care coordination**
  Our robust medical management program provides you and your family a valuable resource for one-on-one support and guidance to the right programs and services.
- **Hospital stays**
  In an emergency, you have coverage. However, requests for nonemergency hospital stays (other than maternity stays) and some types of outpatient care must have prior authorization or be preauthorized. This lets Cigna determine if the services are covered by your plan.

  If your provider is in the Cigna OAP network, he or she will arrange for prior authorization. If you use an out-of-network provider, you must make the arrangements.
- **Out-of-pocket costs**
  Depending on your plan, you may have to pay an annual amount (deductible) before your plan begins to pay for covered health care costs. You may also need to pay a copay and/or coinsurance (a portion of the covered charge) for covered services. Then, your plan pays the rest. Once you reach an annual limit on your payments (out-of-pocket maximum), the health plan pays your covered health care costs at 100% for the rest of your plan year.

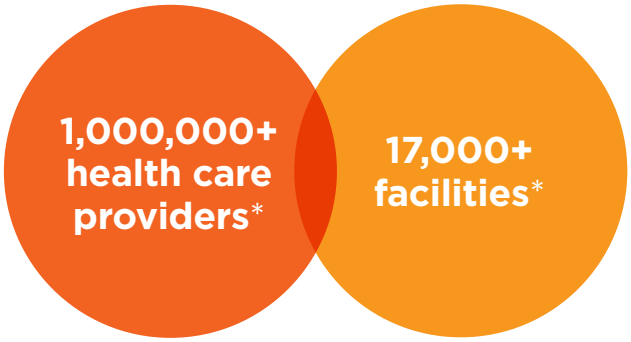
  If you receive out-of-network care, your costs will be higher. Out-of-network providers and facilities may also bill you for charges that are not covered by the plan. Charges not covered by the plan do not contribute to your deductible or out-of-pocket limits.

Together, all the way.®

Cigna®

Offered by Cigna Health and Life Insurance Company.

Great care anywhere. Where you live, work or travel



Added convenience and support

- **Virtual Care**
  Connect 24/7 with board-certified providers and pediatricians for minor medical conditions. You can also schedule online appointments for licensed counselors or psychiatrists for behavioral or mental health conditions. You and your covered family members can get care from anywhere via video or phone.**
- **Cigna Health Information Line**
  With the Cigna Health Information Line, clinicians are just a phone call away – 24/7, and at no extra cost. They can help you understand health issues you might be experiencing, and help you to make informed decisions – whether it's reviewing home treatment options, following up on a provider's appointment, or choosing and finding the right care in the right setting.
- **Live, 24/7/365 customer service**
  Customer service representatives are here for you where and when you need us – over the phone, via chat at **myCigna.com** or on the myCigna® App.
- **The myCigna website and app**
  On **myCigna.com** and the myCigna App, you have easy access to personalized tools to help you take control of your health and your health care spending. From your computer or mobile device, you can:
  - Manage and track claims
  - See cost estimates for medical procedures
  - Compare quality information for providers and hospitals
  - Track your account balances and deductibles
  - Use the easy health and wellness tools
  - Print a temporary ID card

Want to check if your provider is in the Cigna OAP network before you enroll?

Just go to Cigna.com and click on "Find a Provider, Dentist or Facility" and then click on "Plans through your employer or school" to search the provider directory.

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* Based on Cigna internal provider data for OAP service area as of 2/2020. Subject to change.

** Not all plans include coverage for behavioral services. Check your plan documents for details. Cigna provides access to virtual care through national telehealth providers as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers. This service is separate from your health plan's network and may not be available in all areas. A primary care provider referral is not required for this service. In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

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CHOICE. QUALITY. PEACE OF MIND.

Open Access Plus and Open Access Plus In-Network Plans

Employees may struggle to keep up with their financial, social, emotional and physical health, while you continue to face the ongoing challenges of managing health care costs. By providing choice, Open Access Plus (OAP) allows employees to get the quality, affordable, whole-person care they want, while helping you get the cost savings you need.

Benefits for you

Helping you control costs

Open Access Plus and Open Access Plus In-Network plans help control medical expenses and provide choices for quality, affordable care with:

- Negotiated network-specific discounts and fee schedules
- Flexible plan designs that can allow for an array of cost-sharing options, including copay, coinsurance and deductible
- Robust medical management to help reduce use of nonessential procedures
- Cost Containment Programs that help to manage costs associated with out-of-network care and lower out-of-pocket costs for your employees
- Additional savings opportunities when you choose to combine medical, pharmacy and behavioral programs

Benefits for your employees

The choice they need

Our plans are designed to provide cost-savings without sacrificing network access and coverage for your employees, while supporting their overall well-being.

- A nationwide network of quality health care professionals and facilities
- The right guidance to high performing providers[2] that are recognized for achieving the best health outcomes and savings
- Virtual Care services that allow employees and their families to access care without leaving home or work. They can connect 24/7 with board certified physicians and pediatricians for minor medical conditions and schedule online appointments with licensed counselors or psychiatrists for behavioral or mental health conditions from anywhere via computer or smartphone[3]
- 24/7 help, guidance and support live on the phone, online or through the myCigna app
- Care coordination for employees and their families with medical management services that provide one on one support

Together, all the way.®

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Offered by Cigna Health and Life Insurance Company

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Whole health support

Open Access Plus offers employers a total benefit solution. In addition to providing access to a strong nationwide network of health care professionals and encouraging the use of in-network providers, other key features and benefits to support your employees' total well being at no additional cost include:

- **Cigna Health Information Line** – 24/7 access to nurses who can help answer health questions
- **myCigna.com and the myCigna® App** – provides access to personalized plan information and offers cost and quality tools that can simplify choice and help employees save money
- **Health Assessment** – confidential questionnaire that identifies a person's potential future health risk, creates a personalized report, and offers information about health and wellness programs
- **24/7/365 Service** – one number to call for health and claims information, available 24/7/365 and translation available in more than 200 languages
- **Healthy Rewards®[4]** – discounts on weight management and fitness programs along with a host of alternative wellness and preventive products and services

A variety of optional incentive programs are also available for rewarding employees who actively participate in specific healthy behaviors or activities.

More about our plans

- Open Access Plus provider coverage for in-network and out-of-network care
- Open Access Plus In-Network provider out-of-network covereage for emergency care only
- In order to encourage in-network utilization and comply with our provider contracts, benefit plan coinsurance levels must have a minumum 20% differential between in-network and out-of-network
- Benefit plan design flexibility for plan deductible, copay and/or coinsurance for certain services
- Multiple funding arrangement types are available to suit your needs
- Ability to integrate your medical plan with a HRA (health reimbursement account)
- Ability to integrate a HSA (health savings account) when the plan design follows IRS guidelines for a high deductible plan
- PCP recommended, but not required. No referral requirements. Individuals can self-refer to a specialist

We can help you offer a plan that serves all of your employees, with tailored solutions for multiple sites or locations.

Help your employees take control of their health – body & mind. To learn more, please call your broker or Cigna representative today.

1. Based on Cigna internal provider data for OAP service area as of 2/2020. Subject to change.
2. Providers identified as having top results, based on Cigna's 2020 Quality, Cost Efficiency, and Cigna Care Designation Methodology White Paper. Some doctors are included in Tier 1 due to contractual obligations and network adequacy requirements and may not meet Cigna quality and/or cost-efficiency measures.
3. Not all plans include coverage for behavioral services. Check your plan documents for details. Cigna provides access to virtual care through national telehealth providers as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers. This service is separate from your health plan's network and may not be available in all areas. A primary care provider referral is not required for this service. In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered.
4. Healthy Rewards is a discount program. If your plan includes coverage for any of these services, this program is in addition to, not instead of your plan benefits. Healthy Rewards programs are separate from your medical benefits. **A discount program is NOT insurance, and the customer must pay the entire discounted charge**. Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

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CIGNA TOTAL BEHAVIORAL HEALTH®

Comprehensive, personalized support for lasting behavioral change

Americans need behavioral health support now more than ever. Consider this:

1 in 4 struggle with depression since stay-at-home orders[1]

53% feel their mental health has been negatively impacted[2]

30% have developed Generalized Anxiety Disorder[3]

1/3 of people working from home during the pandemic report drinking during work hours.[4]

The Cigna Total Behavioral Health program helps you manage health issues in your workforce before they become more serious. We do this through a combination of behavioral, wellness and pharmacy components. We identify and engage individuals with behavioral health issues, as well as those with undiagnosed and untreated needs. This is key in light of a study[5] that showed over one third of individuals with medical conditions also have a behavioral health condition, which may never be appropriately treated. Our comprehensive approach is designed to improve whole health – and your bottom line.

We connect whole health. To support the whole person.

With Cigna Total Behavioral Health, you get:

- Innovative, evidence-based clinical programs and services focused on reducing the negative impact of behavioral issues.
- A personalized customer experience to support individuals – and their families.
- Emotional well-being programs and tools:
  - **Services to help manage life events** include three face-to-face visits[6] with a licensed mental health professional in our Employee Assistance Program[7] network. Live chat with an Employee Assistance Program consultant, unlimited telephonic counseling and access to work-life resources are included. Customers have access to legal services, financial services and identity theft support. On-demand online seminars as well as convenience services such as referrals for child care, eldercare, adoption, home repair and more are included.
  - **Happify[8] offered through Cigna** – Provides digital self-directed tool designed to help employees build resilience and reduce stress. With more than 60 tracks on topics, such as conquering negative thoughts, improving relationships and boosting self-esteem, Happify offers science-based activities, games and guided meditations that help employees build resilience and improve emotional health.
  - **iPrevail[8] offered through Cigna** – Provides on-demand peer coaching and personalized learning plans based on established cognitive behavioral therapies. Individuals use a chat function to pair with a trained peer specialist who has faced challenges of their own with depression, substance use and other behavioral challenges. Individuals engage with peer coaches or work through learning lessons and activities on their own. iPrevail also includes a caregiver support program designed to help customers cope with stress, improve resiliency and enhance their overall health and well-being.

Together, all the way.®

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- More than 45 years of experience delivering behavioral health programs designed to prevent relapse and hospital readmission. **A study showed our in-network facilities have 18% less readmissions and cost less than half as much as out of network facilities.**[9]
- A large, national network of behavioral health care providers. Includes national virtual network, online scheduling and text messaging. Fast Access network guarantees appointment scheduling in five business days.[10] Appointment scheduling assistance provided.
- 24/7/365 crisis and emergency support for your employees
- **Customer advocacy** ensures every customer who calls or chats with us is contacted to confirm their needs have been met.[11]
- **Predictive analytics** help get ahead of customer needs before they become acute by navigating to affordable, convenient digital, coaching and virtual care options.[11]
- Predictive models help identify high-risk customers who can benefit from additional support, education and help finding in-network providers.
- Ginger behavioral health coaching via text-based chats, self-guided learning activities and content, and, if needed, video-based therapy and psychiatry. [8,12]
- A guided approach that makes it simple to access in-network facilities and providers to help ensure customers are achieving better and more cost-efficient outcomes. **This is key, as using out of network providers results in, 33% longer length of treatment and two and a half times higher cost.**[13]
- Peace of mind regarding claim risk, as we fund covered in-network behavioral claims. This includes behavioral services for all mental health and substance use disorder diagnoses, including Applied Behavior Analysis (ABA) for the treatment of Autism. A Cigna study showed the average annual cost of ABA per customer is $60,000 and potential annual cost of ABA per customer is $400,000.[14]
- A care coaching model that is designed to empower sustainable behavior change and lead to lasting results.
- **myCigna.com includes guided navigation** which provides customers with real-time, customized options based on their acuity level and available digital, virtual and in-person programs and services.[11]
- Tools to manage out-of-network substance use treatment and costs. Includes predictive identification, customer education and Centers of Excellence (COE) for Substance Use. **Out-of-network Substance Use facilities cost 240% more than our COEs for Substance Use, and, they have a 71% higher readmit rate than our COEs.**[15]
- Our Centers of Excellence[16] program identifies in-network behavioral facilities that have earned a top ranking based on our measures of patient outcomes and cost-efficiency. With locations nationwide, our program includes Centers of Excellence for Adult Mental Health, Child and Adolescent Mental Health, Eating Disorders and Substance Use.
- Help for people with hard-to-treat conditions, such as chronic pain, who want to feel better physically and emotionally.
- **Online resources available on Cigna.com and myCigna.com** provide easy access to behavioral awareness series information, articles, podcasts and the provider directory. You can also visit the employer section of our **pain resource hub** on **Cigna.com**, which outlines strategies designed to help reduce the impact of opioid use in your workplace.

CIGNA TOTAL BEHAVIORAL HEALTH'S INTEGRATED DESIGN HELPS DRIVE BETTER HEALTH, OUTCOMES AND SAVINGS.

$227 per member per year medical cost savings when you connect Medical, Behavioral and Pharmacy benefits[17]

How we do it – Comprehensive and personalized support every step of the way

Cigna Total Behavioral Health creates more opportunities to proactively engage customers in the right treatment and coaching, at the right time. Increasing the use of these important services helps drive improved health, lower utilization and lower costs.

INPATIENT CASE MANAGEMENT

Support for those needing hospitalization for mental illness or substance use treatment, including detoxification and residential treatment. Case managers work with the individual, their family and outpatient professionals to coordinate services and help ensure safe and effective treatment upon discharge.

OUTPATIENT CASE MANAGEMENT

Dedicated outpatient support for those leaving the hospital, including partial hospitalization and intensive outpatient treatment. Outreach to individuals and health care providers to provide education, appointment reminders and follow-ups on medication compliance. Plus, there is no prior authorization required for routine care.

INTENSIVE BEHAVIORAL CASE MANAGEMENT

For individuals with complex mental health or substance use conditions who are at high risk for readmission. Dedicated case managers reach out to support individuals as often as necessary. They act as liaisons to patient and family after discharge.

GAPS IN CARE

Proprietary screening model used to review all claims. Identifies evidence-based behavioral gaps in care. Enables targeted outreach and intervention.

SPECIALTY COACHING & SUPPORT SERVICES

Our Coaching and Support services provide dedicated support for a broad range of conditions including autism, eating disorders, intensive behavioral case management, substance use and opioid and pain management. We also provide coaching and support for parents and families, which empowers individuals to be to be effective advocates for their child, spouse, or family member-or their own mental health needs.

Our dedicated behavioral coaches and case managers support your employees – and their families. Our team uses a multidisciplinary approach to help ensure treatment is effective and appropriate. They coordinate with health care professionals and refer to our pharmacy and wellness programs. They also help overcome barriers to treatment and promote engagement through education and referrals to local support groups and seminars.

Our Coaching and Support services include a digital interface through Vela[8] to supplement coaching. Coaches help customers acquire the app which enables secure two-way messaging, as well as the ability to share resources and support specific to customer needs. Appointment tracking on a shared calendar is also featured.

Free Veteran Support Line - Helps veterans with a wide range of needs such as pain and stress management resources, including Mindfulness for Vets program, as well as counseling for substance use and opioids, financial and legal assistance, and parenting and child care.

First responders – Our teams are trained to address the unique challenges and concerns of first responders and their families. We provide education on the confidentiality of our programs, virtual behavioral services and online resources tailored to the first responder's needs.

99% of participants were very satisfied with the service their case manager provided.[18]

Autism spectrum disorders[19]

- **69%** lower medical inpatient costs per participant per year
- **47%** lower emergency room utilization

Eating disorders program[20]

- **$2,274** lower total medical costs per participant per year

Substance use disorder program[21]

- **$4,080** lower out-of-network costs per participant per year
- **$888** lower emergency room costs per participant per year

Coaching and support for children and families[22]

- **6%** lower behavioral costs post program for participants
- **53%** higher medication adherence rate for participants
- **5%** lower emergency room utilization
- **17%** increase in percentage of participants with outpatient visits within 60 days[24]

Coaching and support for young adults[23]

- **22%** lower total medical costs, and 22% lower total behavioral costs, post program for participants
- **15%** increase in the percentage of participants with outpatient visits within 60 days[24]
- **13%** higher medication adherence rate for participants
- **6%** lower emergency room utilization

LIFESTYLE MANAGEMENT

We include a bundle of three lifestyle management programs to help customers quit tobacco, lose weight and manage stress. Customers can choose telephonic or online coaching, or both. They work with a dedicated wellness coach to help understand reasons for and barriers to change. Our studies show the programs improve health.

For example, 95% of participants remain tobacco-free during outcomes call after graduation.[25]

Cognitive behavioral modification

Support for those who suffer from physical ailments with no clear treatment path, such as chronic pain and migraines. Through one-on-one coaching and support groups, members learn to manage their symptoms to feel better physically and emotionally.

Complex psychiatric case management

Gives physicians and psychiatrists a solution to help patients taking multiple psychotropic drugs. Helps foster appropriate levels of care and adherence to drug therapies to optimize treatment regimens and help decrease potential emergency room visits or hospitalizations.

Narcotics therapy management

Uses comprehensive medical information to identify and address potential inappropriate use of narcotics and other controlled substances. Encourages better management of pain by offering tools and resources, and addressing fraud and abuse.

97% felt the program was useful

95% of program participants reported improved physical health

98% of program participants reported improved emotional health[26]

$2,700 total cost-savings per participant. 99% of savings from avoided inpatient, outpatient and emergency room visits[27]

$2,700 total cost-savings per participant. 99% of savings from avoided outpatient and emergency room visits[27]

Better health, better bottom line

With Cigna Total Behavioral Health, we help our customers improve their health, optimize productivity and lower overall costs. We do this with a whole-person approach to health – mind and body. We manage health issues proactively through a combination of wellness, medical and pharmacy components.

We offer a 1.5% reduction in medical, pharmacy and behavioral claim costs in year one when you add Cigna Total Behavioral Health to your new or existing medical plan.

Not available in all states. Some restrictions apply. Contact your Cigna representative for details.

To learn more about our comprehensive offering, contact your Cigna sales representative.

1. Mental Health America, Data Shows Impacts of COVID-19 on Mental Health. https://nationalhealthcouncil.org/blog/mental-health-america-data-shows-impacts-of-covid-19-on-mental-health. 06/2020.
2. KFF.org. The Implications of COVID-19 for Mental Health and Substance Use. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use. 02/2021.
3. KFF.org. Adults Reporting Symptoms of Anxiety or Depressive Disorder During COVID-19 Pandemic. https://www.kff.org/other/state-indicator/adults-reporting-symptoms-of-anxiety-or-depressive-disorder-during-covid-19-pandemic/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. 02/2021
4. Alcohol.org. Drinking Alcohol When Working from Home. https://www.alcohol.org/guides/work-from-home-drinking. 2021
5. Cigna Behavioral Health Insights, Cigna Book of Business claims data 4-1-17 through 3-31-18 for customers/clients who purchased behavioral and medical through Cigna. Adults only.
6. Three face-to-face visits per issue per year. Restrictions apply to fully insured business situsedin New York.
7. Employee assistance program services are in addition to, not instead of, your health plan benefits. These services are separate from your health plan benefits and do not provide reimbursement for financial losses. Customers are required to pay the entire discounted charge for any discounted legal and/or financial services. Legal consultations related to employment matters are excluded. Additional restrictions may apply. Program availability may vary by plan type and location, and are not available where prohibited by law.
8. Program services are provided by independent companies/entities and not by Cigna. Programs and services are subject to all applicable program terms and conditions. Program availability is subject to change. These programs do not provide medical advice and are not a substitute for proper medical care provided by a physician. Information provided should not be used for self-diagnosis. Always consult with your physician for appropriate medical advice. References to third-party organizations and/or their products, processes or services, doesn't mean Cigna endorses them
9. Cigna Behavioral Health Insights, 2019 National book of business study compared inpatient and outpatient readmission and cost per admission claims data.
10. Per our agreement with contracted providers. Within 5 business days for first time appointment with non-prescriber; 15 business days for prescriber.
11. Available beginning Q3 2022.
12. Cigna provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs.
13. Cigna Behavioral Health Insights, 2019 Health Care Practitioner Efficiency Analysis, Retrospective Claims Analysis of Behavioral Health Professional claims matched by age and licensure level. National study compared claims data for outpatient services not subject to utilization management.
14. 2020 Cigna Book of Business Claims Study.
15. Cigna 2018 and 2019 book-of-business claims study (6/1/18 through 5/31/19). Costs refer to allowed amounts, 30-day calendar readmissions, an industry metric.
16. The Cigna Center of Excellence designation is a partial assessment of quality and cost-efficiency and should not be the only basis for decision-making (as such measures have a risk of error). Individuals are encouraged to consider all relevant factors and talk with their physician about selecting a health care facility. Quality designations and ratings found in Cigna's online provider directories are not a guarantee of the quality of care that will be provided to individual patients. Providers are solely responsible for any treatment provided and are not agents of Cigna.
17. Cigna 2020 National book of business study of medical customers who have Cigna pharmacy + Cigna Total Behavioral Health benefits vs. those with Cigna medical + basic behavioral. Individual client/customer results will vary and not guaranteed. Average annual per member per year (PMPY)
18. Cigna Satisfaction Survey, 2020.
19. Cigna Analytics, Autism Specialty Program Evaluation, 2020.
20. Cigna Analytics, Eating Disorder Specialty Program Evaluation, 2021.
21. Cigna Analytics, Substance Use Specialty Program Evaluation, 2019.
22. Cigna Analytics, Coaching and Support for Children & Families Program Evaluation, 2017. Results derived from National book of business analysis using retrospective comparison analysis.
23. Cigna Analytics, Coaching and Support for Young Adults Program Evaluation, 2017. Results derived from National book of business analysis using retrospective comparison analysis.
24. Outpatient therapy helps the individual and family learn how to overcome the challenges inherent in their day-to-day lives.
25. Cigna Operations, all segment book of business results derived from Lifestyle Management Program data and satisfaction survey, 2017.
26. 2020 Cigna CLIMB participant survey.
27. Cigna Pharmacy program evaluation. Updated 2017. Results derived from National book of business study using retrospective comparison analysis.

Individual client/customer results will vary and are not guaranteed.

The National Committee for Quality Assurance (NCQA) Managed Behavioral Health Organization Accreditation for Cigna Behavioral Health, Inc. applies to Commercial and Marketplace products and Cigna Behavioral Health CA accreditation applies to Commercial products. Full accreditation is a three-year accreditation and is national in scope.

All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and complete details of coverage, contact your Cigna sales representative.

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CASE MANAGEMENT EMPLOYER TOOLKIT

Higher engagement means healthier results for you and your employees

Introduction

Thank you for collaborating with Cigna to help your employees embrace a healthier, more informed culture for your organization.

Our goal is to help and support your employees who need it most. If one of your employees is anticipating a hospital stay, is leaving the hospital or has cancer, we'll likely be contacting them to offer personalized assistance during what is often a challenging time.

Cigna case managers make the health care journey easier and less overwhelming for your employees. They're here to help them understand the types of services Cigna offers and how to participate in their own care.

The first step in developing that collaboration is to build awareness.
We've developed this toolkit to help ensure your employees are aware of the Cigna Case Management Program, which includes access to their Personal Nurse Advocate.*

About this toolkit

This convenient, easy-to-use toolkit contains a variety of case management communication materials — including email, flyers and brochures. Each piece of this communications campaign is designed to help you inform your employees about the benefits of working with their Personal Nurse Advocate, as well as the additional support and services available to them as part of their health plan benefits.

Cigna®

Overview

The Cigna Case Management Program provides your employees with whole-person support.

Cigna's Case Management team is made of nurses, health coaches, pharmacists and other staff who work behind the scenes to help them manage their health conditions. They have **trained health care specialists with the skills, experience and compassion to assist your employees** in accessing necessary medical or mental health services.

What does Case Management do?

Supported by Cigna's staff of board-certified physicians, our Case Managers work closely with each employee, their family and health care providers to:

- Coordinate access to care, including referrals and prior authorizations.
- Monitor progress toward established health goals.
- Assist with coordinating discharge plans and follow-up.
- Ensure their benefits are used effectively.

How does Case Management work?

The Case Management team has your employees' medical histories at their fingertips. This data, combined with Cigna's proprietary predictive models, allows us to identify potential events, provide the best possible outcome and manage health care needs to drive affordability. During each assessment, Personal Nurse Advocates screen for behavioral health needs, as well as social determinants of health, in turn providing education and referrals in order to best support each employee's well-being.

Who qualifies for Case Management?

While anyone can self-refer for Case Management, it is especially helpful for customers who:

- Have more serious health concerns, such as a major accident or prolonged hospital stay.
- Need help finding resources for specialists, or a transition to or from a hospital setting.
- Require frequent emergency room visits or other out-of-network services.

Benefits

How Case Management supports your employees when they need it most

Life is full of surprises. But they can be particularly hard to navigate if you have challenging health care needs. That's where Cigna's Case Management Program can make a difference for your employees, ensuring we never miss an opportunity to coordinate the care they need.

Better service

Case Managers have real-time access to clinical information. This means that, for each employee, a historical record of their prior authorization requests, hospitalizations, referrals to Case Management, claim information and lab information is available to assist in their care management needs. Our clinicians and support staff have access to customer case notes and previous determinations — everything they need to offer service and care.

Identification of gaps in care

Cigna's Case Management Program is designed to isolate and solve gaps in each customer's care. By carving out Case Management from employee health care benefits, opportunities to close gaps could be lost.

The Cigna Case Management difference

People

Cigna's Case Management team features an average of 26 years of nursing experience and 11 years of case management experience. Every day, they combine enhanced case management tools and collaboration with specialized physicians. Their expertise and knowledge far surpass most competitors with a shared service model. In the dynamic and ever-changing health care landscape, understanding the latest clinical information can lead to transformative outcomes for employees.

Trust

When we call your employee, the Personal Nurse Advocate always identifies themselves with their name, title and position with Cigna. He or she also tells your employee about the services available to them. Remember, this service is optional; your employee can stop at any time or decline without penalty to any offerings.

Create a timeline

Timing	Item
Week 1	We Have a Whole Team Waiting for You!
Week 2	I Have a Doctor, So Why is Cigna Calling Me?
Week 3	Why is Cigna Calling Me?
Campaign wrap-up	Complementary and Confidential

Note: Campaign schedule can be adjusted to best fit your organization.

Tips for getting started

Ensure that your leadership team supports the campaign.

Confirm the campaign dates.

Decide which communication formats (email, flyer, or both) will work the best for your workforce.

Your care management marketing materials

Downloadable creative assets and communication plan to help you spread the word

We've designed these convenient communication tools to help you educate your employees about the benefits of Cigna's case management program. The following flyers and ecards can be used at various points. Use them to meet the unique needs of your workforce. Share the flyers the way you like — whether you prefer print them out for in-person distribution at a meeting, or pass them along virtually through email or company intranet.

Case Management Health Advocacy Customer Brochure

DOWNLOAD: ENGLISH | SPANISH

Case Management Personal Nurse Advocate Customer Flyer

DOWNLOAD: ENGLISH | SPANISH

Specialty Case Management Flyer

DOWNLOAD: ENGLISH | SPANISH

"Complementary and Confidential" eCard

DOWNLOAD

"Why is Cigna Calling Me?" eCard

DOWNLOAD

"I Have a Doctor, So Why is Cigna Calling Me?" eCard

DOWNLOAD

"We Have a Whole Team Waiting for You!" eCard

DOWNLOAD

Thank you

Our goal is to help your employees focus on one thing: themselves. That's why our Case Managers work to:

- Keep employees, families and providers informed and involved in treatment decisions.
- Help employees follow through on treatment.
- Provide education and communication.
- Deliver a holistic, personalized care plan for employees.
- Save your employees money by directing care and educating them about their care plans.

Best of all, Cigna's Case Management Program provides patient-centered care to help create savings for your organization.

To learn more, please contact your Cigna sales representative.

Cigna®

* These nurse advocates hold current nursing licensure in a minimum of one state but are not practicing nursing or providing medical advice in any capacity as a health advocate.

Cigna Smart Support® Program

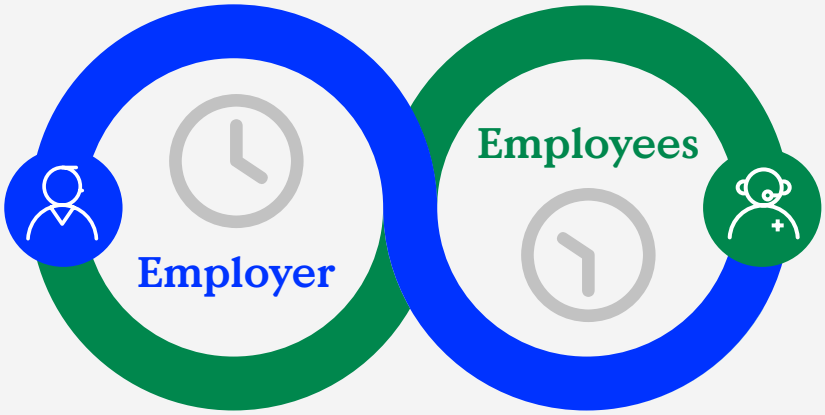
An enhanced level of service designed specifically for government and education clients.

Our Cigna Healthcare℠ Smart Support® Program is an **end-to-end service** offering created to promote government and education employee wellness and manage costs. You can expect dedicated, multidisciplinary teams to support you and your employees. And a tailored benefits strategy that specifically matches your population's needs.

Smart Support offers best-in-class,

24/7

support for the public sector.



Tailored benefits strategy and teams

- Sales, proposal management, quality/technical review and underwriting teams dedicated to the public sector.
- Collaboratively-built benefits plans based on industry best practices, state dynamics and employees health needs.
- Simplified implementation process supported by dedicated Implementation Managers.
- Employee communications for a seamless transition.
- A dedicated Smart Support call team with 24/7/365 live customer service.
- A team of personal Health Care Advocates.
- My Personal Champion® program, which provides a single point of contact for employees who need additional support during periods of complex medical care.
- Wellness tools on myCigna.com® and the **myCigna®** app.

Let's discuss how we can serve you and your employees.

To learn more about Cigna Healthcare benefits and programs designed for the public sector, contact your Cigna Healthcare representative or visit our industry-specific pages:

- State and Local Government
- K-12 School Districts
- Higher Education

Offered by Cigna Health and Life Insurance Company

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, contact a Cigna Healthcare representative.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (Bloomfield, CT) (CHLIC), or its affiliates. In Utah, all products and services are provided by Cigna Health and Life Insurance Company (Bloomfield, CT). Policy forms: OK – HP-APP-1 et al., OR – HP-POL38 02-13, TN – HP-POL43/HC-CER1V1 et al. (CHLIC); GSA-COVER, et al. (CHC-TN).

Pharmacy information available through myCigna 24/7.

We want to help you get the most from your pharmacy benefits and that means getting the information you need when you need it. The best place to start is myCigna® – your "go-to" for everything you need to know about your plan's coverage.

See which medications your plan covers. You have hundreds of generic, preferred brand and non-preferred brand medications to choose from.

Compare your medication costs. Prescription prices vary by pharmacy. Use the Price a Medication tool to see how much your medication may cost at the different retail pharmacies in your plan's network and through Express Scripts Pharmacy®, our home delivery pharmacy. You can also see if there are lower-cost alternatives available.*

Easily manage all of your prescriptions on the My Medications page.
Click on the Prescriptions tab in the myCigna menu to access My Medications

- View your prescriptions filled within the last 18 months
- Use the myCigna App to review your medications with your doctor during an office visit
- Move your prescription from a retail pharmacy to home delivery with the click of a button
- For retail pharmacy fills: View where and when you last filled your medications
- For home delivery fills: Get real-time order status and tracking, sign up for automatic refills, pay bills online, sign up for a payment plan and more
- For specialty medications: Easily connect to your online Accredo® account to manage orders**

Find an in-network retail pharmacy. If you're on the go, use the **myCigna App** to see a list of pharmacies near you.

View your plan information. See your pharmacy claim history, coverage details and account balances.

Learn more about myCigna. Watch our "Get the Most From Your Pharmacy Benefits" video to learn more about using myCigna, as well as the programs and services available through your pharmacy benefit.

cigna healthcare

* Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.

** Not all plans offer home delivery and Accredo as covered pharmacy options. Please log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to learn more about the pharmacies in your plan's network.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna Healthcare℠ representative.

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CONSULTATIVE ANALYTICS℠

Standard CAP Package – Medical and Pharmacy
ABC Company

Together, all the way.®

Cigna®

Table of Contents

Executive Summary
ABC Company

Medical & Rx Spend

Medical & Rx Trend

	Current PMPY	Trend	Variance from Norm
Total Plan Spend	$6,128.98	10.1%	3.9%
Total Employer Paid	$5,192.00	10.4%	2.2%
Total Member Paid	$936.98	8.5%	15.0%
Medical Spend PMPY	$5,115.93	12.2%	9.3%
Employer Paid - Medical	$4,282.90	12.6%	6.6%
Pharmacy Spend PMPY	$1,013.06	0.5%	-16.7%
Employer Paid - Pharmacy	$909.11	0.8%	-14.6%

Demographics & Financial

	Base	Current	Trend	Norm
Members				
Average Number of Employees	1,552	1,526	-1.7%	
Average Number of Members	2,667	2,556	-4.2%	
Average Employee Age	45.4	45.4	0.2%	
Demographic Factor	1.00	1.01	1.0%	1.00
Cost Trend				
Plan Spend - Medical	$12,162,346	$13,075,034	7.5%	
Plan Spend - Pharmacy	$2,687,827	$2,589,031	-3.7%	
Total Plan Spend	$14,850,174	$15,664,066	5.5%	
Medical Plan Spend PMPY	$4,560.45	$5,115.93	12.2%	$4,681.11
Pharmacy Plan Spend PMPY	$1,007.84	$1,013.06	0.5%	$1,215.82
Total Plan Spend PMPY	$5,568.29	$6,128.98	10.1%	$5,896.93
Performance Indicators				
Cat Claimants in Excess Per K	20.6	19.6	-5.1%	14.8
Cat Plan Spend PMPY(Med+Rx)	$2,557.95	$2,777.92	8.6%	$2,017.61
Non-Cat Plan Spend PMPY(Med + Rx)	$3,010.34	$3,351.07	11.3%	$3,879.32
Network Penetration	92.0%	89.5%	-2.5%	91.0%
Medical Discounts	48.5%	45.5%	-3.0%	53.5%

Population Health & Pharmacy

	Base	Current	Trend	Norm
Population Health Measures				
Chronic Percent of Population	37.0%	38.3%	1.3%	39.3%
Chronic Percent of Cost	82.2%	79.7%	-2.5%	73.6%
Total Health Engagement - % of Pop	26.4%	19.4%	-7.0%	27.9%
Preventive Care Utilization	42.5%	31.4%	-11.1%	48.1%
Well Visit Completions	22.1%	22.4%	0.3%	40.9%
Health Assessment Completions	0.4%	0.3%	-0.1%	8.1%
Gaps in Care Rule Compliance	65.4%	62.6%	-2.8%	69.8%
Pharmacy Indicators				
Generic Dispensing Rate	91.2%	91.9%	0.8%	87.2%
Generic Substitution Rate	97.2%	98.1%	0.9%	96.9%
Specialty Plan Spend PMPY (Rx Only)	$345.34	$265.74	-23.0%	$456.05
Specialty Plan Spend PMPY (Med Only)	$130.29	$62.54	-52.0%	$267.54
Non-Specialty Plan Spend PMPY (Rx only)	$662.50	$747.31	12.8%	$759.76
Prescriptions PMPY(Retail adjusted)	14.35	14.59	1.7%	11.96

Current Period reflects claims incurred between Sep. 2016 and Aug. 2017, paid through Oct. 2017
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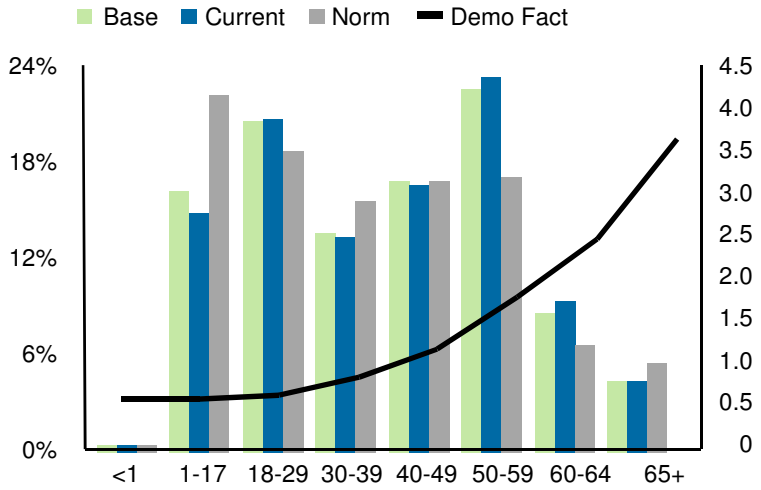
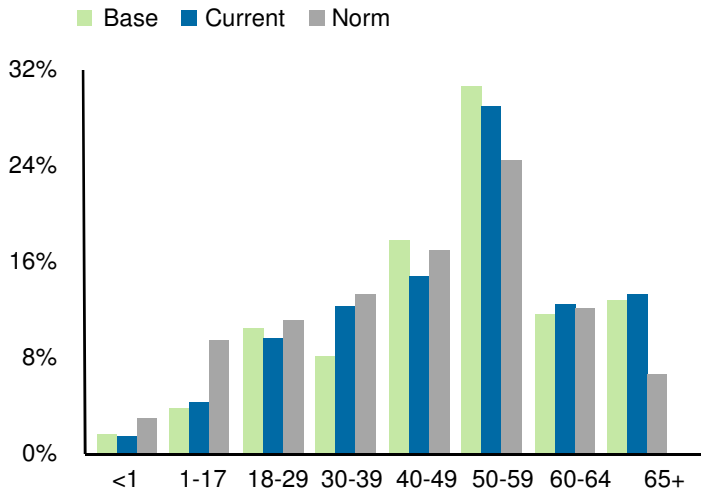
Population Demographic Summary

ABC Company

Percent of membership by age band



Percent of plan spend by age band



Key metrics overview

	Base	Current	Trend	Norm
Percent of Pop. Age 40+	50.8%	52.0%	1.2%	44.7%
Average Member Age	38.2	38.7	1.5%	35.8
Average Employee Age	45.4	45.4	0.2%	46.3
Percent of Population Male	58.7%	58.8%	0.1%	49.7%
Percent of Population Female	41.3%	41.2%	-0.1%	50.3%

Average spend by age band

	Base	Current	Trend	Norm
All Members				
40-49	$6,284	$5,793	-7.8%	$5,836
50-59	$8,010	$8,083	0.9%	$8,244
60-64	$7,980	$8,621	8.0%	$10,470
65+	$17,041	$19,376	13.7%	$6,906
Excluding Catastrophic				
40-49	$3,515	$3,167	-9.9%	$3,958
50-59	$3,926	$4,251	8.3%	$4,988
60-64	$5,023	$5,483	9.2%	$5,826
65+	$6,992	$7,058	1.0%	$4,079

Comments

- Average member age increased from 38.2 years to 38.7 years, an increase of 1.5%
- The percentage of members in the 40+ age range increased from 50.8% to 52.0%, and compares to a norm of 44.7%

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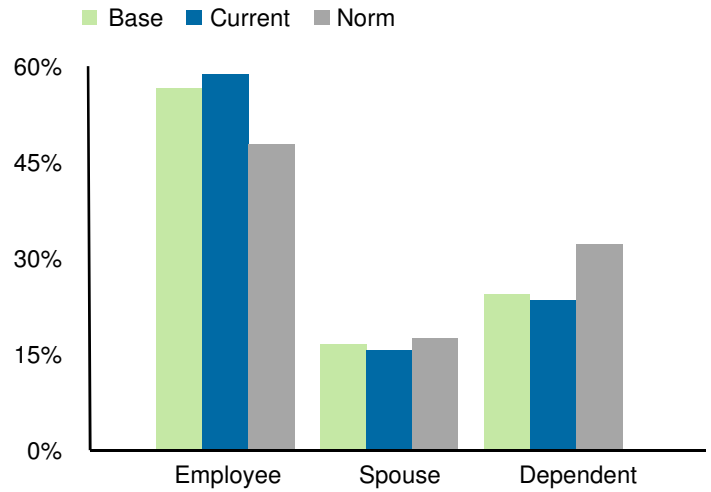
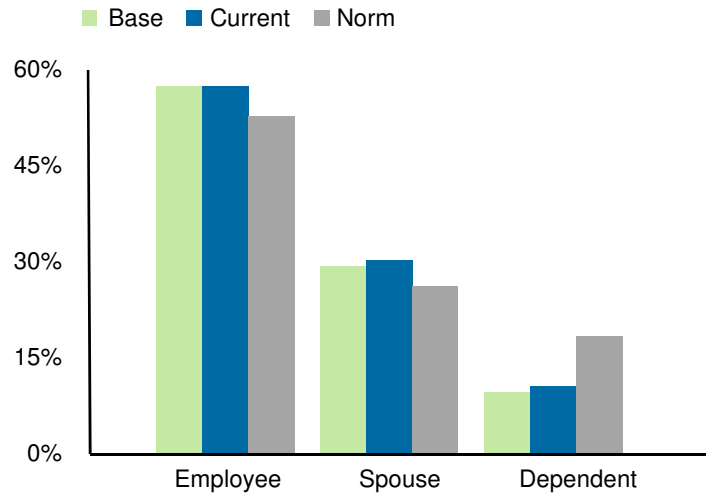
Population Demographics by Relationship

ABC Company

Percent of members by relationship



Percent of plan spend by relationship



Average spend by relationship

	Base	Current	Trend	Norm
All Members				
Employee	$5,664	$6,027	6.4%	$5,979
Spouse	$10,242	$11,463	11.9%	$8,026
Dependent	$2,294	$2,706	18.0%	$3,217
Excluding Catastrophic				
Employee	$3,020	$3,302	9.3%	$3,986
Spouse	$5,822	$5,819	-0.1%	$5,053
Dependent	$1,653	$2,271	37.4%	$2,268

Comments

- Employees represented 59.7% of the population and 58.7% of spend for the current period, versus norms of 49.1% and 53.8%
- By relationship type, spouses incurred higher per member costs than employees, $11,463 PMPY for the current period
- Excluding Catastrophic Claimants, spouses incurred higher per member costs compared to employees, $5,819 PMPY for the current period

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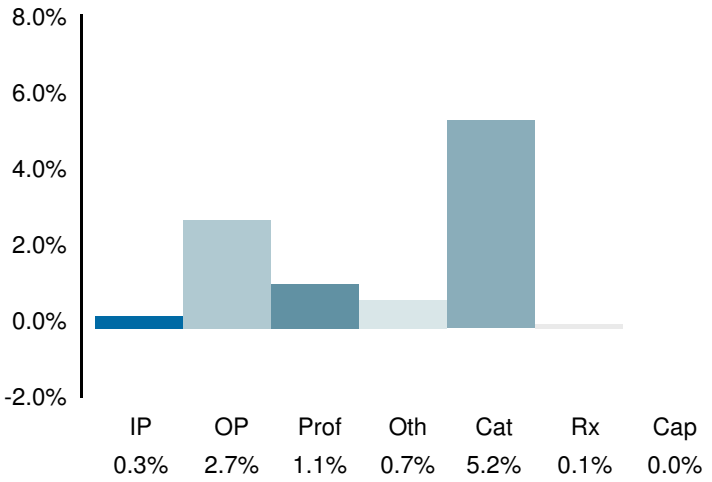
Medical Service Category Trend Analysis

ABC Company

Trend contribution



Account summary (PMPY basis)

	Base	Current	Trend	Trend Contribution	Norm
Non-Catastrophic Plan					
Inpatient	$323	$341	5.4%	0.3%	$369
Outpatient	$1,033	$1,182	14.5%	2.7%	$1,044
Professional	$816	$876	7.3%	1.1%	$1,161
Other	$205	$243	18.4%	0.7%	$270
Total Non-Cat Plan	$2,377	$2,642	11.1%	4.8%	$2,844
Capitation	$0	$0	0.0%	0.0%	$184
Catastrophic Plan	$2,183	$2,474	13.3%	5.2%	$1,653
Total Plan Spend - Medical	**$4,560**	**$5,116**	**12.2%**	**10.0%**	**$4,681**
Cost Share - Medical	$757	$833	10.0%	1.4%	$664
Net Employer Paid - Medical	**$3,803**	**$4,283**	**12.6%**	**8.6%**	**$4,017**
Total Plan Spend - Pharmacy	$1,008	$1,013	0.5%	0.1%	$1,216
Cost Share - Pharmacy	$106	$104	-1.8%	-0.0%	$151
Net Employer Paid - Pharmacy	$902	$909	0.8%	0.1%	$1,065
Medical and Pharmacy Plan Spend	**$5,568**	**$6,129**	**10.1%**		

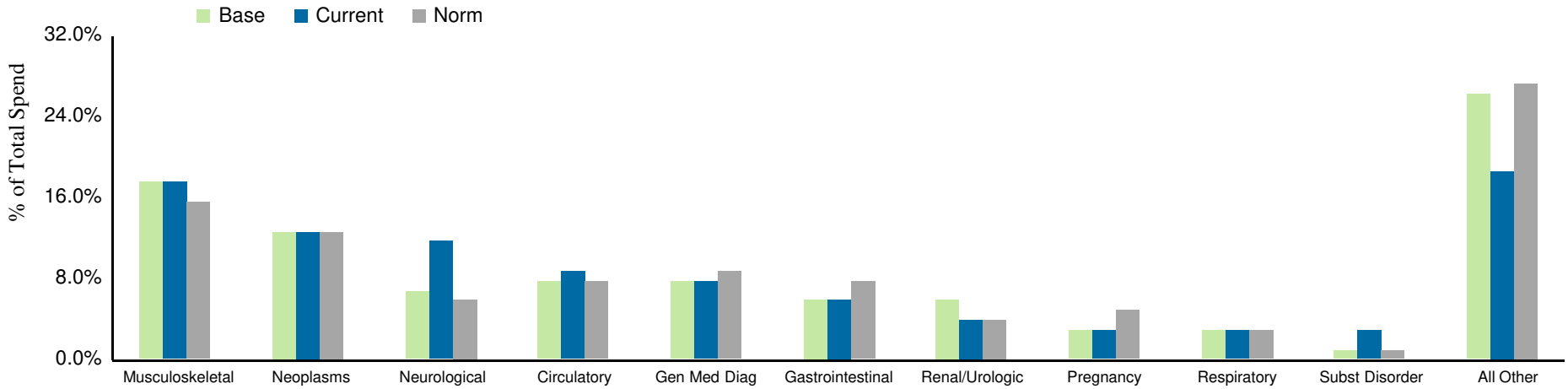
Comments

- Plan spend increased from $5,568 PMPY to $6,129 PMPY, an increase of 10.1%
- Net employer paid increased from $4,705 PMPY to $5,192 PMPY, an increase of 10.4% while member cost share increased from $863 PMPY to $937 PMPY, an increase of 8.5%
- Catastrophic Plan was the largest contributor to trend, contributing 5.2% of the overall 10.1% plan trend
- Trend contribution is a measure of each individual line item's impact on the overall cost change. It is calculated by subtracting the current period result for the item minus the base period result, and dividing this amount by the base period total plan spend

Total Plan Spend by Condition

ABC Company

Top conditions by plan spend



Top ICD conditions

	PMPY				Claimants per 1k			Spend per Claimant		
ICD Category	Base	Current	Trend Contribution	Norm	Base	Current	Trend	Base	Current	Trend
Musculoskeletal	$837.37	$926.20	1.9%	$728.40	274.5	274.3	-0.1%	$3,051	$3,377	10.7%
Neoplasms	$591.22	$666.03	1.6%	$563.38	112.1	112.3	0.2%	$5,273	$5,931	12.5%
Neurological	$298.97	$637.45	7.4%	$269.01	117.4	122.9	4.7%	$2,547	$5,188	103.7%
Circulatory	$352.06	$469.00	2.6%	$359.86	176.2	183.5	4.1%	$1,998	$2,556	27.9%
Gen Med Diag	$349.23	$425.06	1.7%	$408.67	596.6	508.3	-14.8%	$585	$836	42.9%
Gastrointestinal	$290.16	$325.40	0.8%	$343.50	144.0	153.0	6.3%	$2,015	$2,127	5.5%
Renal/Urologic	$282.25	$226.86	-1.2%	$170.14	86.6	85.3	-1.5%	$3,259	$2,660	-18.4%
Pregnancy	$145.82	$177.77	0.7%	$226.15	15.4	22.3	45.1%	$9,485	$7,971	-16.0%
Respiratory	$144.09	$162.51	0.4%	$117.90	100.5	95.9	-4.6%	$1,434	$1,695	18.2%
Subst Disorder	$43.51	$144.83	2.2%	$47.92	18.0	18.4	2.2%	$2,417	$7,876	225.8%
All Other	$1,225.79	$954.80	-5.9%	$1,262.36	1141.8	1130.4	-1.0%	$1,074	$845	-21.3%
Total	**$4,560.45**	**$5,115.93**	**12.2%**	**$4,497.30**	**866.2**	**826.8**	**-4.5%**	**$5,265**	**$6,188**	**17.5%**

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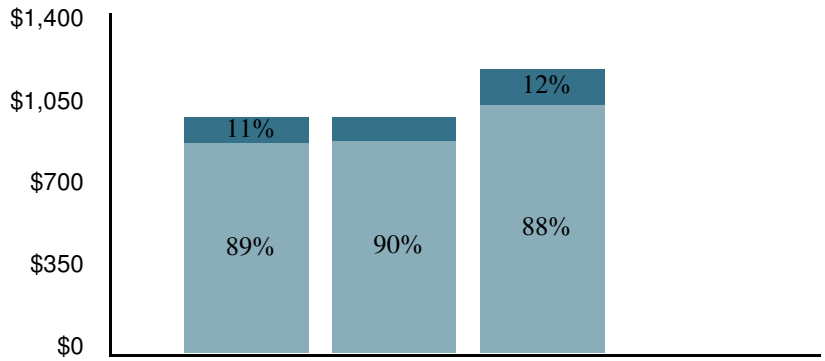
Executive Summary - Pharmacy

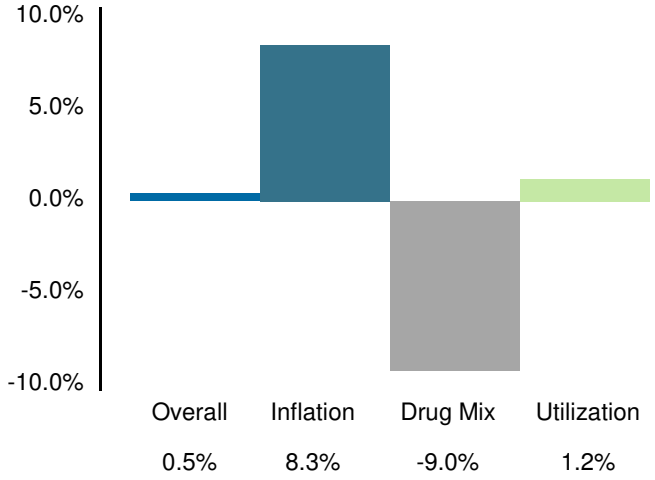
ABC Company

Plan cost & trend



	Base	Current	Norm	Trend
Cost Share PMPY	$105.87	$103.95	$151.05	-1.8%
Paid Amount PMPY	$901.97	$909.11	$1,064.76	0.8%
Plan Spend PMPY	$1,007.84	$1,013.06	$1,215.82	0.5%

Trend impact



Pharmacy performance

	Base	Current	Trend	Norm
Members				
Average Number of Employees	1,552	1,526	-1.7%	
Average Number of Members	2,667	2,556	-4.2%	
Average Utilizers	69.1%	69.6%	0.5%	
Average Member Age	38.1	38.7	1.5%	35.8
Cost Trend				
Plan Spend	$2,687,827	$2,589,031	-3.7%	
Employer Paid	$2,405,485	$2,323,370	-3.4%	
Member Cost Share	$282,342	$265,661	-5.9%	
Drug Mix				
Generic Dispensing Rate	91.2%	91.9%	0.8%	87.2%
Preferred Brand	7.2%	6.4%	-0.8%	9.3%
Non-Preferred Brand	1.7%	1.7%	0.0%	3.5%
Generic Substitution Rate	97.2%	98.1%	0.9%	96.9%
Formulary Brand Compliance Rate	82.2%	80.7%	-1.5%	74.2%
Utilization				
Total Prescriptions	25,040	23,888	-4.6%	
% Mail Order	4.2%	3.7%	-0.4%	8.2%
% Retail	95.8%	96.3%	0.4%	91.8%
% Retail 90	23.1%	24.1%	1.0%	
Days Supply PMPY	390.02	394.64	1.2%	308.07
Specialty Pharmacy				
Pharmacy Plan Spend PMPY	$345.34	$265.74	-23.0%	$456.05
Medical Plan Spend PMPY	$130.29	$62.54	-52.0%	$267.54
Pharmacy Plan Spend as % of Total	34.3%	26.2%	-8.0%	37.5%
Specialty Utilizers	93	78	-16.1%	
Specialty Scripts PMPY	0.07	0.09	19.1%	0.12

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Top Therapeutic Class Trend

ABC Company

Therapeutic class trend driver analysis by plan spend

Rank				Plan Spend PMPY				Unique Members	Utilizing Members	Days Supply PMPY	Inflation
Base	Current	Therapeutic Class	Condition	Base	Current	Trend	Norm	Current	Trend	Trend	Trend
1	1	Insulins	Diabetes	$80.34	$90.16	12.2%	$61.09	50	2.0%	2.9%	16.2%
6	2	Hypoglycemics	Diabetes	$58.88	$75.36	28.0%	$71.82	195	-0.5%	10.3%	25.5%
2	3	Anti-Inflam Disease Modifiers	Arthritis	$75.37	$61.33	-18.6%	$157.72	9	12.5%	-13.0%	-6.9%
5	4	Multiple/Lateral Sclerosis	Multiple Sclerosis	$65.29	$59.47	-8.9%	$64.97	2	-33.3%	-22.7%	-3.1%
8	5	Antivirals, HIV Specific	HIV	$42.83	$54.15	26.4%	$60.09	5	0.0%	-3.8%	24.0%
4	6	Antineoplastics	Cancer	$66.33	$52.54	-20.8%	$62.15	28	33.3%	-17.9%	-5.3%
7	7	Asthma Related	Asthma	$50.25	$50.89	1.3%	$60.18	310	-3.7%	-4.9%	13.4%
9	8	Narcotic Analgesics	Pain	$39.79	$40.93	2.9%	$21.60	486	-6.7%	-5.6%	4.1%
11	9	Lipid Lowering	Cholesterol	$31.51	$32.60	3.5%	$40.37	316	-2.8%	4.2%	-22.4%
10	10	Antipsychotic/Manic	Psychosis	$34.86	$32.02	-8.1%	$18.35	30	-9.1%	8.2%	7.6%
13	11	Antiulcer	Ulcer / Heartburn	$24.28	$27.16	11.8%	$17.87	233	-13.7%	-2.5%	-20.0%
14	12	Anticonvulsants	Seizures	$23.45	$26.85	14.5%	$27.68	160	1.9%	-0.2%	8.5%
3	13	Hepatitis A/B/C	Hepatitis	$74.61	$25.58	-65.7%	$27.77	1	-66.7%	-65.2%	2.3%
33	14	Thyroid/Parathyroid	Thyroid	$7.22	$24.49	239.1%	$11.19	139	-10.3%	-0.3%	2.8%
15	15	Antidepressants	Depression	$19.94	$23.90	19.8%	$29.51	292	-2.0%	5.0%	19.1%
		All Other		$312.87	$335.62	7.3%	$483.44	1,669	-2.4%	0.7%	13.0%
		Total		**$1,007.84**	**$1,013.06**	**0.5%**	**$1,215.82**	**1,799**	**-3.5%**	**1.2%**	**8.3%**

Comments

- The top 15 therapy classes accounted for 66.9% ($677.44) of total plan spend PMPY $1,013.06 in the current period
- There are a number of generic alternatives which could help lower plan spend

Current Period reflects claims incurred between Sep. 2016 and Aug. 2017, paid through Oct. 2017
Base Period reflects claims incurred between Sep. 2015 and Aug. 2016, paid through Oct. 2017

Top Drugs by Volume

ABC Company

Top drugs by volume

Rank				Prescriptions Dispensed			Unique Members		Cost per Script
Base	Current	Drug Name	Condition	Base	Current	Trend	Base	Current	Current
1	1	lisinopril	Hypertension	1,427	1,491	4.5%	186	188	$6.21
2	2	levothyroxine sodium	Thyroid	1,306	1,331	1.9%	136	123	$43.51
3	3	atorvastatin calcium	Cholesterol	1,139	1,303	14.4%	150	160	$19.62
4	4	metformin hcl	Diabetes	1,123	1,209	7.7%	131	137	$6.99
6	5	hydrocodone-acetaminophen	Pain	1,011	933	-7.7%	354	342	$29.86
5	6	omeprazole	Ulcer / Heartburn	1,017	894	-12.1%	166	130	$16.26
7	7	amlodipine besylate	Hypertension	876	704	-19.6%	88	81	$6.78
10	8	losartan potassium	Hypertension	628	671	6.8%	68	69	$11.42
9	9	simvastatin	Cholesterol	670	583	-13.0%	78	63	$10.75
8	10	hydrochlorothiazide	Hypertension	722	580	-19.7%	76	70	$2.95
12	11	gabapentin	Seizures	436	462	6.0%	67	77	$29.26
13	12	lisinopril-hydrochlorothiazide	Hypertension	429	459	7.0%	50	51	$6.35
11	13	metoprolol succinate	Heart/Hypertension	541	453	-16.3%	51	47	$27.41
16	14	metoprolol tartrate	Heart/Hypertension	374	411	9.9%	55	57	$6.10
15	15	amoxicillin	Infection	424	395	-6.8%	323	308	$8.44
17	16	montelukast sodium	Asthma	367	385	4.9%	71	65	$20.72
14	17	pravastatin sodium	Cholesterol	427	366	-14.3%	48	41	$19.09
22	18	ibuprofen	Arthritis / Pain	327	361	10.4%	160	187	$11.30
23	19	sertraline hcl	Depression	317	326	2.8%	48	50	$10.52
18	20	fluticasone propionate	Itching / Inflammation	363	320	-11.8%	130	125	$19.79

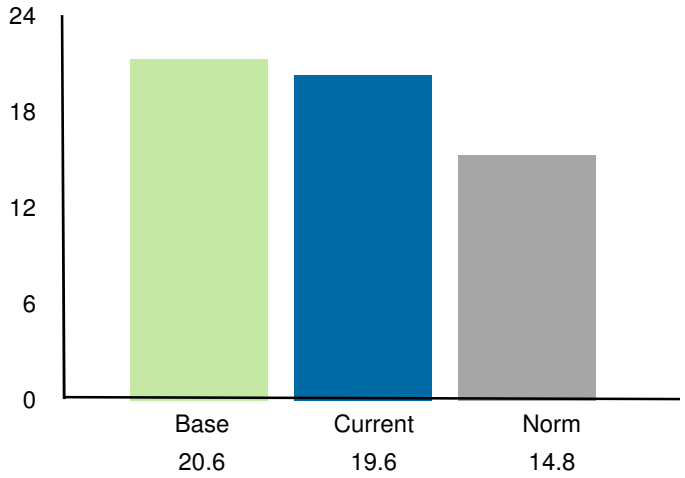
Comments

- The top 20 drugs by volume accounted for 36.6% (13,637) of all prescriptions dispensed but only 9.0% ($2,589,031) of total plan spend in the current period

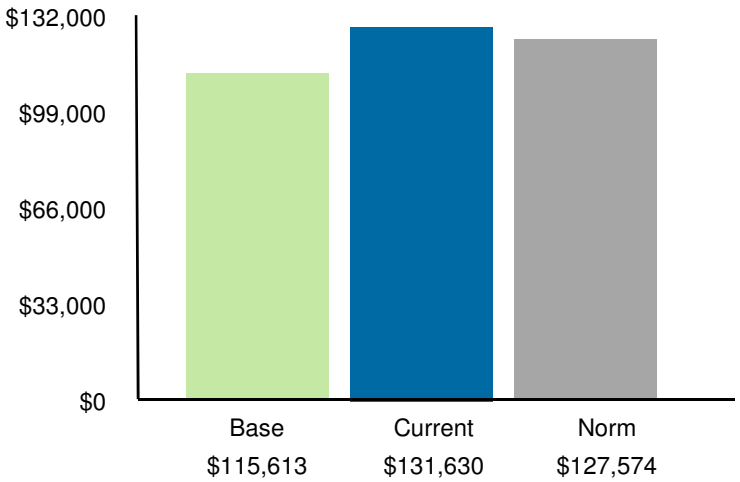
Catastrophic Claim Summary

ABC Company

Catastrophic claimants in excess per 1,000 members



Average plan cost per catastrophic claimant



Account Summary (PMPY Basis)

	Base	Current	Trend	Trend Contribution
Catastrophic Plan Costs				
Inpatient	$981.83	$1,082.98	10.3%	1.8%
Outpatient	$456.89	$647.44	41.7%	3.4%
Professional	$491.10	$463.07	-5.7%	-0.5%
Other	$253.51	$280.80	10.8%	0.5%
Capitation	$0.00	$0.00	0.0%	0.0%
Pharmacy	$374.62	$303.63	-19.0%	-1.3%
Total Catastrophic Plan Cost	$2,557.95	$2,777.92	8.6%	4.0%
Non-Catastrophic Plan Cost	$3,010.34	$3,351.07	11.3%	6.1%
Total Plan Cost	**$5,568.29**	**$6,128.98**	**10.1%**	**10.1%**

Comments

- Plan cost for catastrophic claimants was $2,777.92 PMPY in the current period, or 45.3% of the total plan cost of $6,128.98 PMPY
- Plan cost for catastrophic claimants increased from $2,557.95 PMPY to $2,777.92 PMPY, contributing 4.0% of the overall 10.1% plan trend
- Catastrophic claimants per thousand decreased from 20.6 to 19.6, and compares to a norm of 14.8
- Average cost per claimant increased from $115,613 to $131,630, and compares to a norm of $127,574
- Catastrophic claimant threshold of $50,000 was used for this analysis

Current Period reflects claims incurred between Sep. 2016 and Aug. 2017, paid through Oct. 2017
Base Period reflects claims incurred between Sep. 2015 and Aug. 2016, paid through Oct. 2017

Catastrophic Detail (Integrated Medical and Pharmacy)

ABC Company

	M/F	Age	Relshp	ICD Major	ICD Minor	Medical	Pharmacy	Med Srx	Pharm Srx	Total ($)	Out of Net %	Last Date of Eligibility	Cat in Base?	Clinical Programs
1	M	50-59	EE	Neoplasms	Male Genital	$461,761	$1,631	$44,349	$84,888	$592,630	0%	10/17	Y	WI
2	F	40-49	SP	Musculoskeletal	Back	$469,806	$2,542	$0	$0	$472,348	2%	10/17	N	DEP,LBP,OST,WC,WI
3	F	30-39	EE	Neurological	Head Trauma	$456,094	$2,099	$0	$0	$458,193	64%	03/17	N	
4	M	65+	EE	Neurological	Cerebrovascular	$381,580	$5,910	$0	$0	$387,490	2%	10/17	Y	WI
5	M	50-59	EE	Neurological	Cerebrovascular	$264,903	$12	$0	$0	$264,914	1%	11/16	N	
6	F	18-29	EE	Renal/Urologic	Upper Urinary	$259,822	$587	$0	$0	$260,409	0%	05/17	Y	
7	F	40-49	SP	Int/Ext Injury	Comp Surgical	$117,285	$73,838	$0	$0	$191,123	24%	10/17	Y	WI
8	M	50-59	EE	Neoplasms	Digestive	$135,673	$294	$8,206	$4,974	$149,147	0%	08/17	N	WI
9	F	50-59	SP	Neoplasms	Urinary Neop	$107,448	$38,320	$0	$0	$145,768	0%	10/17	N	WI
10	F	40-49	SP	Neoplasms	Female Genital	$132,280	$1,751	$1,949	$238	$136,217	0%	10/17	N	DEP,OST,WC,WI
11	F	40-49	SP	Circulatory	Veins/Lymph	$130,635	$360	$0	$0	$130,995	98%	10/17	N	WI
12	M	30-39	SP	Subst Disorder	Drug Depend	$130,497	$0	$0	$0	$130,497	97%	10/17	N	
13	F	60-64	EE	Neoplasms	Care/Neoplas	$114,101	$1,240	$9,634	$0	$124,976	2%	10/17	N	WI
14	M	60-64	EE	Musculoskeletal	Joint	$121,336	$2,605	$0	$0	$123,941	4%	10/17	N	WI
15	F	50-59	EE	Circulatory	Ischemic	$122,396	$528	$0	$0	$122,924	37%	10/17	N	WI
16	M	30-39	EE	Subst Disorder	Alc Depend	$119,085	$2,279	$0	$0	$121,364	44%	10/17	N	WI
17	M	65+	SP	Musculoskeletal	Back	$105,213	$13,145	$0	$0	$118,358	0%	10/17	N	WI
18	M	65+	EE	Neoplasms	Other Neopla	$81,577	$6,116	$0	$26,125	$113,818	0%	10/17	Y	DIA,LBP,OST,WC,WI
19	M	65+	SP	Respiratory	Oth Lower Resp	$97,512	$12,917	$0	$0	$110,429	1%	02/17	N	AST,CHF,CPD,WC
20	F	50-59	SP	Neurological	Cerebrovascular	$104,986	$485	$13	$0	$105,484	2%	10/17	N	WI
21	F	60-64	EE	Musculoskeletal	Joint	$97,463	$7,678	$0	$0	$105,140	2%	10/17	N	AST,DIA,OST,WC,WI
22	F	65+	SP	Neoplasms	Female Breast	$102,408	$1,873	$576	$260	$105,117	1%	06/17	N	
23	M	60-64	EE	Circulatory	Artery/Capil	$102,536	$73	$0	$0	$102,608	21%	10/17	N	WI
24	M	18-29	DEP	Subst Disorder	Drug Depend	$89,843	$2,392	$0	$0	$92,235	54%	10/17	N	WI
25	F	65+	SP	Musculoskeletal	Fracture	$90,815	$187	$0	$0	$91,002	31%	09/17	N	WI

Acronym Key

CM/SPCM Programs (Case Mgmt)
- CAT-Catastrophic
- COM-Complex
- INP-Inpatient
- NIC-Neonatal Intensive Care
- ONC-Oncology
- REH-Rehabilitation
- TRN-Transplant

Chronic Coaching Programs
- AST-Asthma
- CAD-Coronary Heart Disease
- CHF-Chronic Heart Failure
- CPD-Chronic Obstructive Pulmonary Disorder
- DEP-Depression
- DIA-Diabetes Mellitus
- LBP-Low Back Pain
- OST-Osteoarthritis
- PAD-Peripheral Artery Disease
- WGT-Weight Complications

Additional Programs
- CCS-Cancer Care Support Program
- EAP-Employee Assistance Program
- HPHB-Healthy Pregnancies Healthy Babies
- LMP-Lifestyle Management Programs
- OL-Online Programs
- TDS-Treatment Decision Support
- WC-Wellness Coaching
- WI-Well Informed (Gaps In Care)

High Cost Prescriptions

ABC Company

High cost prescriptions ranking

Rank				Plan Spend PMPY				Cost per Script	Unique Members		Scripts	
Base	Current	Drug Name	Condition	Base	Current	Trend	Norm	Current	Base	Current	Base	Current
1	1	Harvoni (SRx)	Hepatitis	$74.61	$25.58	-65.7%	$18.37	$32,684	3	1	6	2
-	2	Humira Pen Psoriasis-Uveitis (SRx)	Arthritis	$0.00	$3.69	0.0%	$1.56	$9,441	0	1	0	1
-	3	Evzio	Abuse deterrent	$0.00	$6.27	0.0%	$0.66	$8,011	0	1	0	2
4	4	Tecfidera (SRx)	Multiple Sclerosis	$35.90	$33.20	-7.5%	$15.42	$7,070	1	1	15	12
-	5	Zytiga (SRx)	Cancer	$0.00	$33.22	0.0%	$1.26	$6,529	0	1	0	13
5	6	Copaxone (SRx)	Multiple Sclerosis	$29.39	$26.27	-10.6%	$17.50	$4,197	1	1	17	16
12	7	Orencia (SRx)	Arthritis	$15.10	$18.05	19.6%	$2.69	$3,844	1	1	16	12
-	8	Orencia Clickject (SRx)	Arthritis	$0.00	$15.01	0.0%	$0.35	$3,197	0	1	0	12
7	9	Enbrel (SRx)	Arthritis	$21.22	$6.96	-67.2%	$37.48	$2,964	1	1	14	6
21	10	Forteo (SRx)	Osteoporosis	$11.65	$11.58	-0.7%	$2.69	$2,959	1	1	22	10
16	11	Complera (SRx)	HIV	$3.73	$10.46	180.5%	$2.81	$2,671	1	1	6	10
8	12	Humira Pen (SRx)	Arthritis	$18.62	$17.18	-7.7%	$67.08	$2,439	1	3	13	18
17	13	capecitabine (SRx)	Cancer	$9.30	$5.15	-44.6%	$1.94	$1,879	2	2	15	7
20	14	Latuda	Psychosis	$17.12	$18.70	9.2%	$4.07	$1,837	3	4	31	26
25	15	Prezcobix (SRx)	HIV	$3.62	$6.65	83.6%	$1.12	$1,700	1	1	8	10
22	16	Reyataz (SRx)	HIV	$6.27	$7.52	20.0%	$0.95	$1,479	1	1	12	13
26	17	Xifaxan	Infection	$3.16	$3.47	10.0%	$3.08	$1,479	3	2	7	6
-	18	Tivicay (SRx)	HIV	$0.00	$0.57	0.0%	$2.30	$1,469	0	1	0	1
13	19	Renvela	Electrolyte Imbalance	$9.01	$7.41	-17.7%	$1.69	$1,457	1	1	12	13
-	20	Onfi	Sedatives/Antianxiety	$0.00	$10.08	0.0%	$1.30	$1,431	0	1	0	18

Comments

- The top 20 high cost drugs accounted for 0.6% (208 scripts) of the overall prescription volume, and 26.4% ($267.03) of total plan spend PMPY in the current period

Cigna Health Matters - Engagement Index

ABC Company

Cigna understands that people engage with their health differently at different stages of their life. We also understand that if customers are highly involved in their health then those actions can lead to improved health and ultimately lower costs.

Cigna has launched a new way to measure **population engagement,** called **Cigna Health Matters Engagement Index,** that is grounded in science and provides greater insight into engagement across all of the health and wellness programs and services Cigna offers.

Individuals are considered engaged based on evidence of actions for Health Maintenance and Health Improvement using the following criteria:

2+ Health Maintenance

Health protection: Activities that allow an individual to **maintain health and improve** health behaviors
Health detection: Tests and procedures that allow an individual to **identify** illness

Examples

- Completed preventive service
- Goal set – phone, online or onsite
- Onsite wellness campaigns
- Gaps in Care - 100% compliance or credited closure
- Called into EAP
- Called 24 health information line

OR

Engaged

1+ Health Improvement

Activities that allow an individual to manage and improve their current illness

Examples

- Goal set – phone, online or onsite
- Gaps in Care – credited closure
- Pre/Post admission counseling
- Case Management
- Treatment Decision Support
- Health Pregnancies Healthy Babies
- Onsite lunch & learns

Cigna Health Matters - Engagement Index Summary

ABC Company

Total health engagement as a % of population

Comments

- Cigna's Health Matters Engagement Index provides greater insight into engagement across all of the health and wellness programs and services Cigna offers
- In the current period 19% of the total population has engaged in two or more Health Maintenance actions or one or more Health Improvement actions. This is a decrease of 7% from the base period of 26%. This compares to a norm of 28%
- When engagement is split into Health Maintenance and Health Improvement activities, 17% of the population has completed 2 or more Health Maintenance activities, and 3% of the population completed 1 or more Health Improvement activities during the current period, compared to 24% and 4% respectively in the base period
- When the population is split into segments using ETG methodology, the Chronic Illness segment had the greatest overall engagement at 33% for the current period

Engagement by behavior type and population segment

Segment	Health Maintenance (HM) (2+)			Health Improvement (HI) (1+)			Total Engagement (2+ HM or 1+ HI)		
	Base	Current	Norm	Base	Current	Norm	Base	Current	Norm
Chronic Illness	37%	27%	37%	11%	9%	10%	44%	33%	43%
Major Episode* / Maternity	32%	24%	37%	0%	0%	3%	32%	25%	38%
Minor Episode**	29%	18%	32%	0%	0%	0%	29%	18%	32%
Healthy***	22%	22%	37%	0%	0%	0%	22%	22%	37%
Non User	4%	1%	2%	0%	0%	0%	4%	1%	2%
Total	24%	17%	26%	4%	3%	4%	26%	19%	28%

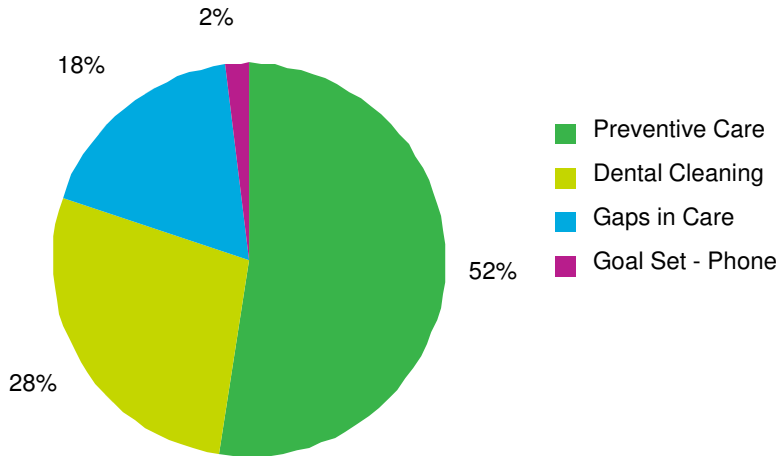
*Major Episode >$500 per episode
**Minor Episode <$500 per episode
*** Healthy - only preventive claims

Current Period reflects claims incurred between Sep. 2016 and Aug. 2017, paid through Oct. 2017
Base Period reflects claims incurred between Sep. 2015 and Aug. 2016, paid through Oct. 2017

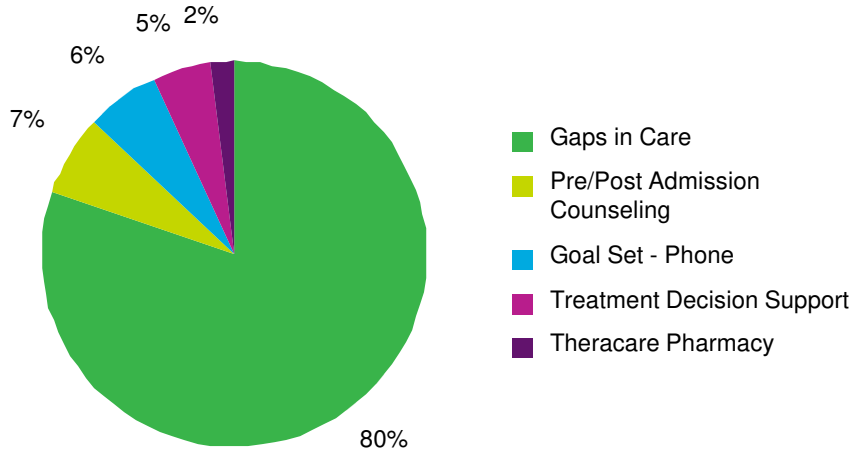
Engagement Index - Top Activities
ABC Company

Top engagement activities

Health Maintenance



Health Improvement



Comments

• It is important to understand the activities that drive engagement. The graph above illustrates the activities most often completed for both Health Maintenance and Health Improvement for those individuals meeting the engagement criteria.

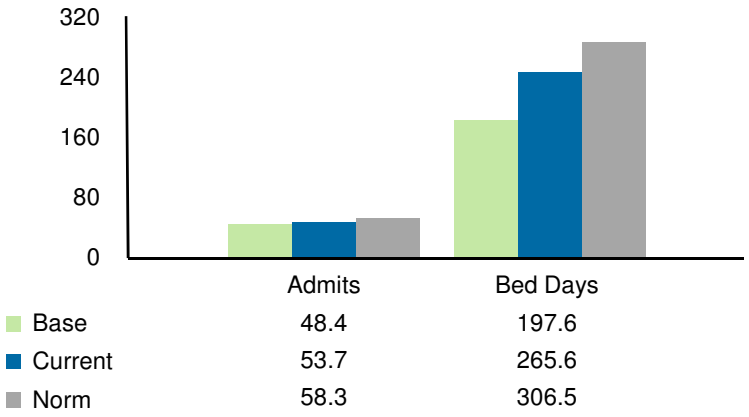
• Top Health Maintenance activities for those meeting the engagement criteria in the current period were, Preventive Care at 52% , Dental Cleaning at 28% and Gaps in Care at 18% . Top Other activities include

• Top Health Improvement activities for those meeting the engagement criteria in the current period were, Gaps in Care at 80% , Pre/Post Admission Counseling at 7% and Goal Set - Phone at 6% .

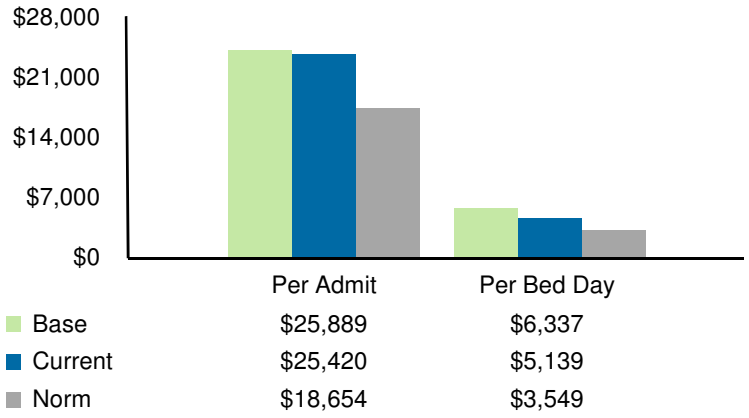
Inpatient Summary

ABC Company

Utilization metrics per 1,000 members



Average cost metrics



Account summary (PMPY basis)

	Base	Current	Trend	Trend Contribution
Non-Catastrophic Inpatient	$323.16	$340.70	5.4%	0.3%
Catastrophic Inpatient	$981.83	$1,082.98	10.3%	1.8%
Total Inpatient	**$1,304.99**	**$1,423.68**	**9.1%**	**2.1%**
All Other Service Categories	$4,263.30	$4,705.30	10.4%	7.9%
Total Plan Cost	**$5,568.29**	**$6,128.98**	**10.1%**	

Comments

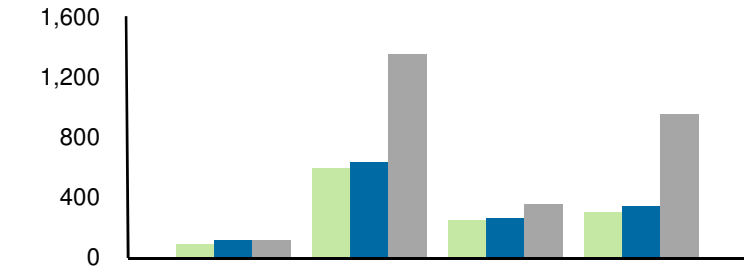
- Non-catastrophic inpatient costs increased from $323.16 PMPY to $340.70 PMPY, contributing 0.3% of the overall 10.1% plan trend
- Utilization increased from 48.4 to 53.7 admits per thousand and increased from 197.6 to 265.6 bed days per thousand
- Cost per admit decreased from $25,889 to $25,420 and decreased for bed days from $6,337 to $5,139

Current Period reflects claims incurred between Sep. 2016 and Aug. 2017, paid through Oct. 2017
Base Period reflects claims incurred between Sep. 2015 and Aug. 2016, paid through Oct. 2017

Outpatient Summary

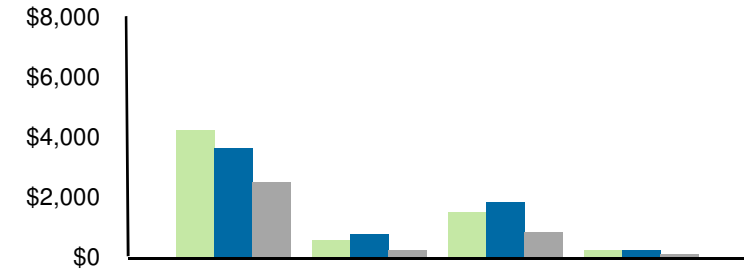
ABC Company

Facility outpatient utilization per 1,000 members



	Surgery	Diagnostic	ER/UC	Other
Base	110.2	647.9	273.7	330.0
Current	129.0	693.6	293.3	378.7
Norm	130.5	1,457.7	395.9	1,027.9

Facility outpatient cost per service



	Surgery	Diagnostic	ER/UC	Other
Base	$4,601	$654	$1,653	$321
Current	$3,926	$868	$2,033	$329
Norm	$2,706	$292	$987	$212

Account summary (PMPY basis)

	Base	Current	Trend	Trend Contribution
Non-Catastrophic Outpatient	$1,032.62	$1,182.14	14.5%	2.7%
Catastrophic Outpatient	$456.89	$647.44	41.7%	3.4%
Total Outpatient	$1,489.51	$1,829.58	22.8%	6.1%
All Other Service Categories	$4,078.78	$4,299.41	5.4%	4.0%
Total Plan Cost	**$5,568.29**	**$6,128.98**	**10.1%**	**10.1%**

Comments

- Non-catastrophic outpatient costs increased from $1,032.62 PMPY to $1,182.14 PMPY, contributing 2.7% of the overall 10.1% plan trend
- Diagnostic was the largest category of utilization. Utilization per thousand increased from 647.9 to 693.6, and compares to a norm of 1,457.7
- Emergency room and urgent care was the next largest category of utilization. Utilization per thousand increased from 273.7 to 293.3, and compares to a norm of 395.9
- Surgery was the largest average cost category. Cost per service decreased from $4,601 to $3,926, and compares to a norm of $2,706
- Emergency room and urgent care was the next largest average cost category. Cost per service increased from $1,653 to $2,033, and compares to a norm of $987

Current Period reflects claims incurred between Sep. 2016 and Aug. 2017, paid through Oct. 2017
Base Period reflects claims incurred between Sep. 2015 and Aug. 2016, paid through Oct. 2017

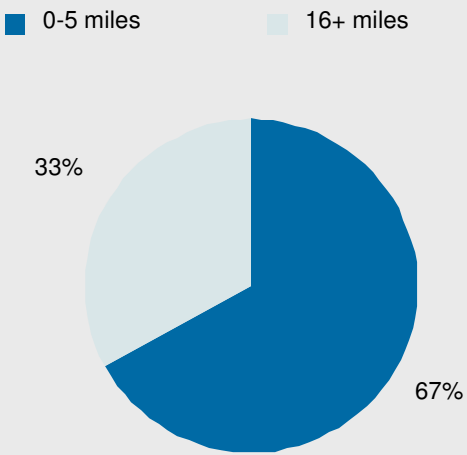
Emergency Room/Urgent Care Opportunity

ABC Company

Cost & utilization trends

	Visits Per 1000			Cost Per Visit			PMPY			Cost Share %
	Base	Current	Trend	Base	Current	Trend	Base	Current	Trend	Current
Emergency Room										
Non-Steerable	234.0	247.6	6%	$1,865	$2,354	26%	$436	$583	34%	23.4%
Steerable	19.9	16.8	-15%	$667	$537	-20%	$13	$9	-32%	74.4%
Urgent Care	19.9	28.8	45%	$147	$146	-1%	$3	$4	44%	48.5%
Office Visits	2,450.8	2,560.8	4%	$147	$147	-0%	$361	$376	4%	25.7%
Convenience Care	6.7	6.4	-5%	$93	$121	30%	$1	$1	24%	25.0%
Telehealth	0.0	0.4	0%	$0	$40	0%	$0	$0	0%	100.0%
Total	**2,731.2**	**2,860.9**	**5%**				**$814**	**$973**	**20%**	

Urgent Care - nearest facility



Emergency Room Steerable

Primary Opportunity for Urgent Care	Plan Cost	PMPY	Total Visits	Cost Per Visit
Ear,Nose,Throat	$5,608	$2.19	11	$497.87
Musculoskeletal	$5,529	$2.16	10	$539.91
Eye	$3,207	$1.25	6	$521.87
Infect/Parasit	$2,054	$0.80	4	$501.49
Renal/Urologic	$1,430	$0.56	2	$698.25
Int/Ext Injury	$1,336	$0.52	1	$1,304.93
Gastrointestinal	$1,159	$0.45	2	$566.03
Skin	$714	$0.28	2	$348.84
Neoplasms	$698	$0.27	1	$681.66
Other	$1,365	$0.53	3	$444.42
Total	**$23,102**	**$9.04**	**43**	**$537.12**
UC Average Cost Per Visit				**$145.77**
Per Visit Redirect Savings				**$391.35**
Opportunity Redirect Savings				
10% Redirect to Urgent Care				$1,683
25% Redirect to Urgent Care				$4,208

**UC Average Cost per visit calculation for steerable opportunity excludes outliers >* $1,500

Comments

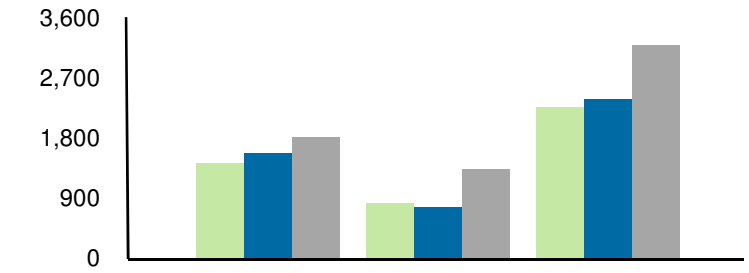
- Urgent care facilities are an accessible low cost alternative to emergency room care for many conditions
- Information on the urgent care facility network is available via the provider directory on myCigna.com
- Current period urgent care cost per visit was $146, compared to emergency room steerable cost per visit of $537
- In the current period, 43 emergency room visits were steerable representing potential redirect savings of up to $16,832
- Of the steerable emergency room visits, 67% had a contracted urgent care facility within 10 miles
- Steerable emergency room cost share percentage is 74.4%, compared to urgent care at 48.5%

Current Period reflects claims incurred between Sep. 2016 and Aug. 2017, paid through Oct. 2017
Base Period reflects claims incurred between Sep. 2015 and Aug. 2016, paid through Oct. 2017

Office Visits

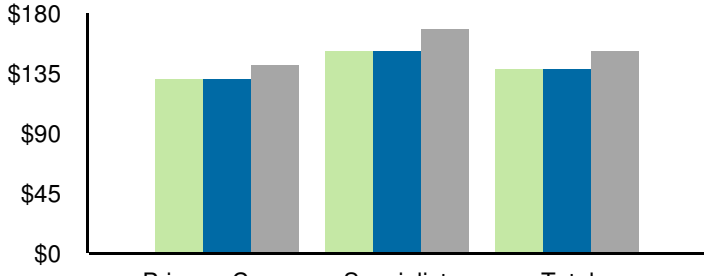
ABC Company

Office visits per 1,000 members



	Primary Care	Specialist	Total
Base	1,546.0	904.4	2,450.8
Current	1,719.0	841.1	2,560.8
Norm	1,954.4	1,451.9	3,412.1

Average plan cost per office visit



	Primary Care	Specialist	Total
Base	$139	$161	$147
Current	$140	$162	$147
Norm	$150	$179	$162

Specialist plan spend

Specialist Plan Spend PMPY	Base	Current	Trend
E&M	$106.80	$100.51	-5.9%
Injectable Rx	$1.77	$3.18	79.5%
Surgery	$11.24	$11.49	2.2%
Cardiology	$0.38	$0.51	32.8%
X-ray	$2.38	$2.54	6.9%
Other	$23.18	$17.62	-24.0%
Total Specialist	$145.75	$135.85	-6.8%
Total Primary Care	$214.83	$239.86	11.7%
Total	**$360.59**	**$375.81**	**4.2%**

Comments

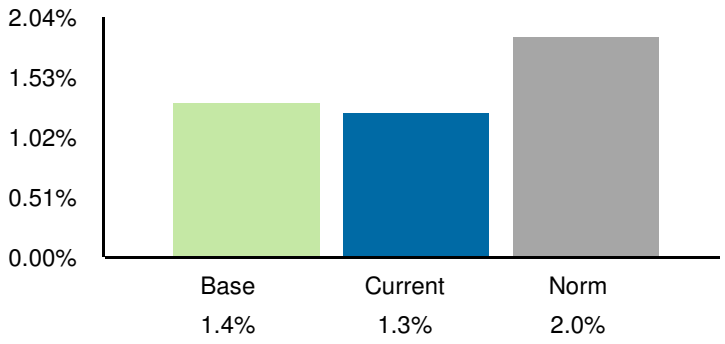
- Office visits per thousand increased from 2,450.8 to 2,560.8, and compares to a norm of 3,412.1
- Cost per visit remained at $147, and compares to a norm of $162
- Plan spend for Specialists in the current period was $136 PMPY compared to $240 PMPY for Primary Care Physicians
- Specialist Evaluation & Management cost decreased from $107 PMPY to $101 PMPY, a decrease of 5.9%

Current Period reflects claims incurred between Sep. 2016 and Aug. 2017, paid through Oct. 2017
Base Period reflects claims incurred between Sep. 2015 and Aug. 2016, paid through Oct. 2017

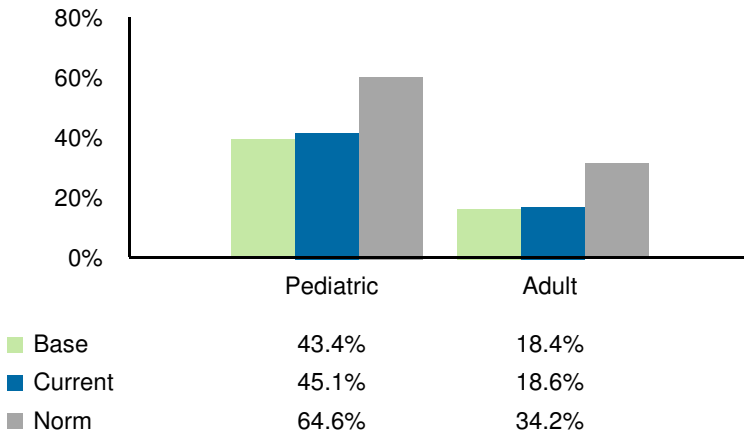
Preventive Care Summary

ABC Company

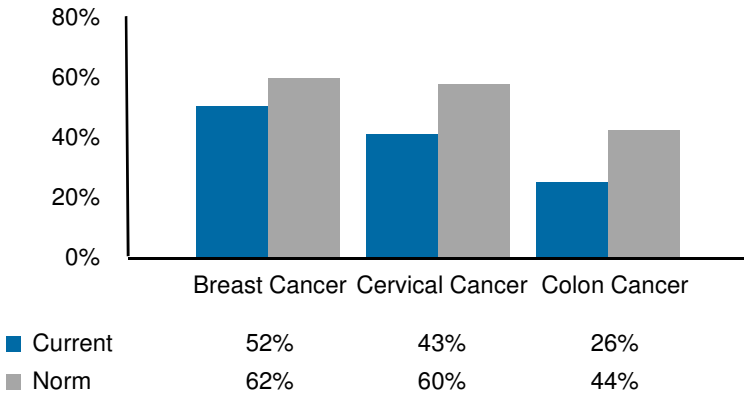
Preventive care as % of total spend



Well visit completion rates



Cancer screening rates



Comments

- Preventive care as a percent of total spend decreased from 1.4% to 1.3%, and compares to a norm of 2.0%
- Well visit completion rate for adults increased from 18.4% to 18.6%, and compares to a norm of 34.2%
- Breast cancer screening rate was 52%, 10% less than the norm of 62%
- Cervical cancer screening rate was 43%, 17% less than the norm of 60%
- Colon cancer screening rate was 26%, 18% less than the norm of 44%

*Results are based on HEDIS ® technical specifications, but some variance will exist due to differences in claims data availability compared with specification criteria
-Breast Cancer Age Criteria: 42-69 24 Month Eligibility
-Cervical Cancer Age Criteria: 24-64 24 Month Eligibility
-Colon Cancer Age Criteria: 51-75 24 Month Eligibility

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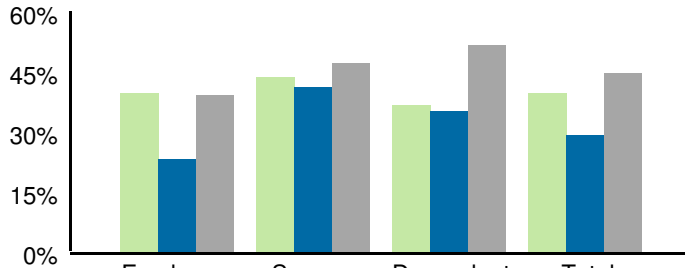
Preventive Care - Population Profile

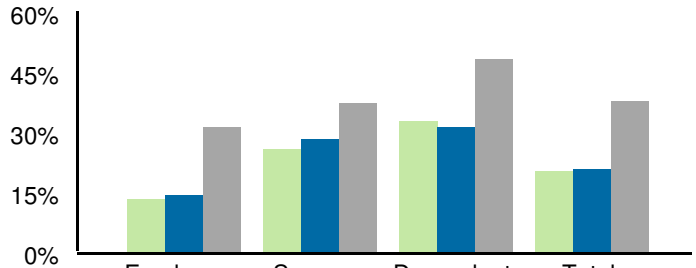
ABC Company

Preventive care utilization (all services)



	Employee	Spouse	Dependent	Total
Base	42.5%	47.0%	39.6%	42.5%
Current	25.2%	44.5%	38.1%	31.4%
Norm	42.3%	50.5%	55.5%	48.1%

Well visit completion rates



	Employee	Spouse	Dependent	Total
Base	14.8%	27.7%	35.3%	22.1%
Current	15.6%	30.7%	33.6%	22.4%
Norm	33.8%	40.2%	51.9%	40.9%

Comments

- The largest category of preventive care utilization is spouses. The utilization rate decreased from 47.0% to 44.5%, and compares to a norm of 50.5%
- The next largest category of preventive care utilization is dependents. The utilization rate decreased from 39.6% to 38.1%, and compares to a norm of 55.5%
- The largest category of well visit utilization is dependents. The utilization rate decreased from 35.3% to 33.6%, and compares to a norm of 51.9%
- The next largest category of well visit utilization is spouses. The utilization rate increased from 27.7% to 30.7%, and compares to a norm of 40.2%

Clinical Program Savings Summary

ABC Company

Program	Estimated Savings Current	Impacted Members/Events Current
Chronic Condition Coaching	$252,396	771
Lifestyle Coaching	$0	0
Wellness Coaching	$1,167	4
Treatment Decision Support	$0	0
Specialty CM	$0	0
Gaps in Care	$14,808	104
IP/OP UM	$0	0
Health Information Line	$0	0
Total	**$268,371**	

CM - Case Management IP - Inpatient OP - Outpatient UM - Utilization Management

Comments

- The Health Matters programs use claims data mining, health risk assessments, and other sources to identify individuals who might benefit from coaching to manage their condition. This is the way Cigna understands your population
- Health Matters Score is then used to connect customers to the optimal engagement modality, online or telephonic, based on health opportunities and derived preferences
- Total savings driven from the clinical programs purchased in the current period were $268,371
- The programs driving the greatest amount of savings were Chronic Condition Coaching and Gaps in Care

Current Period reflects claims incurred between Sep. 2016 and Aug. 2017, paid through Oct. 2017
Base Period reflects claims incurred between Sep. 2015 and Aug. 2016, paid through Oct. 2017

Glossary

Acute
An illness of short duration (as opposed to chronic illness).

Admission
An overnight confinement to a facility.

Admissions Reviewed
Activity performed by a nurse prior to a scheduled admission to identify and address any issues, challenges or gaps.

Brand Name
The proprietary or trade name of the medication.

Breast Cancer Screening
Measures the percent of qualified women 40-69 years of age that are compliant with mammogram screening.

Capitation
Arrangement where network providers receive a set dollar amount of money per covered member assigned to their practice, even if no services rendered.

Cardiac catheterization
A medical procedure used to diagnose and treat certain heart conditions.

Case Management
Coordination of services to help meet a patient's health care needs, usually when the patient requires multiple services from multiple providers.

Catastrophic
Term used to describe when a member has accumulated payments in excess of $50,000 for a specified time period.

Centers of Excellence
Cigna's defined network of facilities deemed superior in status due to their clinical and financial performance in providing patient care.

Cervical Cancer Screening
Measures the percent of qualified members greater than 29 years of age who received at least one pap smear.

Chronic
Defined as an illness or sickness that is not curable but may be controlled with treatment.

Chronic Obstructive Pulmonary Disease (COPD)
Defines a group of diseases characterized by airflow obstruction and includes chronic bronchitis and emphysema.

Churn
Those members who either enrolled or disenrolled or did both during the analysis period (includes newborns).

Coinsurance
The percentage of covered expenses paid by the member when costs are being shared by both the plan and the individual member.

Colon Cancer Screening
Colorectal Cancer Screening (CRC) can detect pre-malignant polyps and guide their removal, which in theory can prevent the development of colon cancer.

Convenience Care
Treatment for common family ailments such as strep throat, pinkeye and athlete's foot

Coordination of Benefits (COB)
The amount saved when Cigna is the secondary insurer. It represents the difference between what Cigna pays and (COB) what it would have paid if it were primary.

Copay
Predetermined fees for medical services covered by a benefit plan, which are paid by the member at the time of service.

Glossary

Coronary angioplasty
A medical procedure in which a balloon is used to open a blockage in a coronary (heart) artery narrowed by atherosclerosis, improving blood flow.

Coronary Artery Bypass Graft (CABG)
Surgery where blood flow is rerouted through a new artery or vein that is grafted around diseased sections of coronary arteries.

Cost Share
Benefit plan arrangement requiring that the participant pay a portion of the costs. This includes copayments, coinsurance and deductibles.

Covered Charges
Net charges minus the items not covered by the benefit plan. Items not covered include charges for ineligible services, network discounts, etc.

CT
A diagnostic imaging scan also called a Cat Scan (computed tomography).

Deductible
An amount specified in plan design that must be paid by member for covered expenses in a benefit period before the plan will pay benefits.

Denied Charges
Amounts not covered due to lack of information about the claim.

Diagnostic Testing
Refers to other significant testing procedures not named - examples include: doppler electrocardiograph, cardiac ultrasound and sleep studies.

Discounts
Amounts reduced by a contractual fee arrangement with network participating providers, prompt pay arrangements, or Hospital Savings Program (HSP).

Emergency Room - Diagnostic Groupings
Musc - Musculoskeletal
ENT - Ear/Nose/Throat
Skin - Skin
Resp - Respiratory
Circ - Circulatory
Dig - Digestive
Inj - Injury

Episode Treatment Group (ETG)
An illness classification methodology derived by analyzing actual claim experience and clinical review.

Esophagitis (digestive)
Inflammation of the lining of the esophagus, the tube that carries food from the throat to the stomach.

Evaluation and Management (E&M)
E&M services refer to visits and consultations furnished by physicians.

Facility
A site where health care services are delivered including hospitals, convalescent units, skilled nursing facilities, and birthing centers.

Facility Outpatient
Refers to services and costs that are incurred at a facility but did not result in an admission.

Fee for Service
Compensating providers for rendering patient care which is based on an as services are rendered basis.

Gastroenteritis (digestive)
A condition that causes irritation and inflammation of the stomach and intestines (the gastrointestinal tract).

Glossary

Generic Drug
A prescription drug that has the same active-ingredient formula as a brand-name drug.

Generic Efficiency
This metric illustrates the rate of generic utilization for drugs in which a generic option is available.

Health Advisor (HA)
Registered nurses provide highly personalized management outreach and coaching to help members navigate through healthcare choices.

Health Advocacy
Health Advocacy is the term Cigna uses to describe the process we use to improve health and lower costs for our customers and members.

Health Information Lines (HIL)
Supports effective self care offsite by providing convenient access to a registered nurse and audio library.

Healthy Babies Program
A voluntary prenatal program which offers expectant parents educational materials. Early prenatal care is essential in reducing infant mortality.

Healthy Pregnancies Healthy Babies Program (HPHB)
HPHB is a comprehensive maternity management program, where goal is to reduce the number of pre-term and underweight babies.

Inpatient
Refers to services and costs that are incurred during a facility admission.

Lipotropics
Drugs which are designed to lower cholesterol and triglyceride levels which help reduce amount of overall fatty substances in the blood.

Mail Order Drugs
A feature of a pharmacy program that enables a participant to send their prescription (and any applicable copay) directly to a mail-order vendor.

Maintenance Drugs
Medications that are prescribed for long-term treatment of chronic conditions, such as diabetes, high blood pressure or asthma.

Major Diagnostic Categories (MDC)
Industry standard groupings of ICD diagnostic codes which relate to various body systems for inpatient and outpatient claims.

Major Joint (musculoskeletal)
Examples of what comprises this category are: major joint and limb reattachments, hip or knee replacement.

MRI
Magnetic Resonance Imaging - a type of diagnostic test

Network Dollar Penetration
All charges submitted by in-network providers as a percentage of overall charges.

NICU
Neonatal Intensive Care Unit which provides a high level of intensive care to premature infants

Non-Preferred Brand Drug
Drugs in the third tier of a pharmacy program, brand-name drugs that either have generic equivalents or may have one or more preferred brand options.

Norm
Norm refers to the comparison group based on book of business or industry experience for the defined parameters. Norms are annualized unless otherwise stated.

Glossary

Office visit
Services delivered by a physician, clinician, or practitioner within the confines of a professional office setting.

Orthopedic
A branch of medicine concerned with the correction or prevention of deformities, disorders, or injuries of the skeleton (tendons and ligaments)

Other Medical (cardiac)
Some examples of what comprises this category: hypertension, vascular procedures and angina.

Other Surgical (cardiac)
Some examples of what comprises this category: major cardiovascular procedures, circulatory disorders and pacemaker.

Outpatient
Refers to services and costs that are incurred outside of a facility admission.

PET scan
Positron Emission Tomography scan (specialized imaging)

Pharmacy Payments
Includes prescription drug expenses paid under a pharmacy program. These expenses would not include drugs covered under the medical benefit plan.

PHS
PHS requires precertification of coverage primarily for inpatient care.

PHS+
PHS+ required precertification of coverage for both inpatient care and certain select outpatient services.

Pre-Certification
Process of confirming eligibility and collecting information prior to inpatient admissions and selected ambulatory procedures and services

Predictive Model
System of using historical claims data to stratify members and identify those who can best benefit from case management and/or disease management.

Preferred Brand Drug
Drugs in the second tier of a Cigna HealthCare two or three tier pharmacy program which have no generic equivalent.

Preventive Care
Measures taken to prevent illness or injury and may include examinations/screening tests tailored to an individual's age, health, and family history.

Primary Care Practitioner
Include physicians and nonphysician primary care practitioners whom members are able to select as primary care practitioners.

Professional
This category includes primary care physicians, specialists (oncologists, cardiologists, neurologists, obstetricians, etc.), surgeons, etc..

Retail
Relates to services rendered by participating retail pharmacies.

Script
A dispensed prescription.

Specialty Case Management
Case management programs targeted to impact specific diseases and conditions - examples include oncology, rehab and high risk maternity.

Spinal fusion
A surgical procedure used to correct problems with the bones (vertebrae) of the back (spine).

Glossary

Therapeutic Class
Major therapeutic classes include Central Nervous System, Cardiovascular, Hormonal, Anti-infectives, Pain, Allergy/Respiratory and other drugs.

Unique Claimants
A count of members who had one or more claims processed for a benefit plan during a specified time period.

Valve Replacement
Example of what comprises this category: cardiac valve and other major cardiothoracic procedures.

Well Visits
Designed to discuss general health and any problems, then focus on general disease prevention and health maintenance on a regular basis

Report Parameters

ABC Company

Global Parameters

Overall Dates

	Current	Base
Incurred	09/2016 to 08/2017	09/2015 to 08/2016
Incurred Runout	09/2016 to 10/2017	09/2015 to 10/2017

Catastrophic Threshold	$50,000
Exclude Pharmacy	No

Package :987708

Package Name:	**ABC Company**
Structure:	Status = *, Division = *, Products = Base,Choice,Standard,NOSTRUC,Unassigned
Package Parameters	PMPY,BCN,Override:No
Normative Values	201704

Sample Florida OAP Certificate

OPEN ACCESS PLUS MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2025

SAMPLE

This document printed in June, 2024 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Sample Florida OAP Certificate

GROUP POLICY(S) — COVERAGE

0000000 - OAP OPEN ACCESS PLUS MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2025

THE BENEFITS IN THIS CERTIFICATE CONTAIN A DEDUCTIBLE PROVISION

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

Geneva Cambell Brown, Corporate Secretary

HC-CER5 04-10
V1

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

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

Special Plan Provisions

When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health 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.

Services Available in Conjunction With Your Medical Plan

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.

HC-SPP63 01-20

Case Management

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, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) 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.

HC-SPP2 04-10
V1

Additional Programs

We 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 members. We may also arrange for the reimbursement of all or a portion of the cost of services

provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

HC-SPP3 04-10
V1

Incentives to Participating Providers

Cigna continuously develops programs to help our customers access quality, cost-effective health care. Some programs include Participating Providers receiving financial incentives from Cigna for providing care to Members in a way that meets or exceeds certain quality and/or cost-efficiency standards, when, in the Participating Provider's professional judgment, it is appropriate to do so within the applicable standard of care. For example, some Participating Providers could receive financial incentives for utilizing or referring you to alternative sites of care as determined by your plan rather than in a more expensive setting, or achieving particular outcomes for certain health conditions. Participating Providers may also receive purchasing discounts when purchasing certain prescription drugs from Cigna affiliates. Such programs can help make you healthier, decrease your health care costs, or both. These programs are not intended to affect your access to the health care that you need. We encourage you to talk to your Participating Provider if you have questions about whether they receive financial incentives from Cigna and whether those incentives apply to your care.

HC-SPP81 01-24

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.

HC-SPP27 06-15
V1

Important Notices

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 Drug Products included on the Prescription Drug List. These rebates or remuneration are not obtained on you or your Employer's or plan'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 may also conduct business with various pharmaceutical manufacturers separate and apart from this plan's Medical Pharmaceutical and Prescription Drug Product 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 Drug Products. 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 Product 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 Product 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 Product, 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 Product, 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.

HC-IMP260 01-20
V10

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service 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 number on the back of 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 or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

HC-NOT96 07-17

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки

участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY : اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese –
注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711را شمارەگیری کنید).

HC-NOT97 07-17

Federal CAA - Consolidated Appropriations Act and TIC - Transparency in Coverage Notice

Cigna will make available an internet-based self-service tool for use by individual customers, as well as certain data in machine-readable file format on a public website, as required under the Transparency in Coverage rule. Customers can access the cost estimator tool on myCigna.com. Updated machine-readable files can be found on Cigna.com and/or CignaForEmployers.com on a monthly basis.

Pursuant to Consolidated Appropriations Act (CAA), Section 106, Cigna will submit certain air ambulance claim information to the Department of Health and Human Services (HHS) in accordance with guidance issued by HHS.

Subject to change based on government guidance for CAA Section 204, Cigna will submit certain prescription drug and health care spending information to HHS through Plan Lists Files (P1-P3) and Data Files (D1-D8) (D1-D2) for an Employer without an integrated pharmacy product aggregated at the market segment and state level, as outlined in guidance.

HC-IMP324 01-23

Federal CAA - Consolidated Appropriations Act

Continuity of Care

In certain circumstances, if you are receiving continued care from an in-network provider or facility, and that provider's network status changes from in-network to out-of-network, you may be eligible to continue to receive care from the provider at the in-network cost-sharing amount for up to 90 days from the date you are notified of your provider's termination. A continuing care patient is an individual who is:

- Undergoing treatment for a serious and complex condition
- Pregnant and undergoing treatment for the pregnancy
- Receiving inpatient care
- Scheduled to undergo urgent or emergent surgery, including postoperative
- Terminally ill (having a life expectancy of 6 months or less) and receiving treatment from the provider for the illness

If applicable, Cigna will notify you of your continuity of care options.

Appeals

Any external review process available under the plan will apply to any adverse determination regarding claims subject to the No Surprises Act.

Provider Directories and Provider Networks

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

A list of network pharmacies is available to you, without charge, by visiting the website or 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.

Provider directory content is verified and updated, and processes are established for responding to provider network status inquiries, in accordance with applicable requirements of the No Surprises Act.

If you rely on a provider's in-network status in the provider directory or by contacting Cigna at the website or phone number on your ID card to receive covered services from that provider, and that network status is incorrect, then your plan cannot impose out-of-network cost shares to that covered service. In-network cost share must be applied as if the covered service were provided by an in-network provider.

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan 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, access the website or call the phone number on 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, access the website or call the phone number on your ID card.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these situations, you should not be charged more than your plan's copayments, coinsurance, and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**". This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care – such as when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

- **Emergency services** – If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as a copayments, coinsurance, and deductibles). You cannot be balanced billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Certain non-emergency services at an in-network hospital or ambulatory surgical center –** When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balanced billed.

If you get other types of services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you have these protections:

- You are only responsible for paying your share of the cost (such as copayments, coinsurance, and deductibles that you would pay if the provider were in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval in advance for services (also known as prior authorization).
  - Cover emergency services provided by out-of-network providers.
  - Base what you owe the provider or facility (cost sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits (EOB).
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you have been wrongly billed, contact Cigna at the phone number on your ID card. You can also contact No Surprises Help Desk at 1-800-985-3059 or http://www.cms.gov/nosurprises for more information about your rights under federal law.

HC-IMP325 01-23

How To File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network 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 calling 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 BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT 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.

If it was not reasonably possible to give proof in the time required, Cigna will not reduce or deny the claim for this reason if the proof is submitted as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified unless the claimant was legally incapacitated.

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

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V2

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees as determined by your Employer; and

- you are an eligible Employee as determined by your Employer; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Eligibility for Dependent Insurance

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

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

Waiting Period

Initial Employee Group: As determined by your Employer.

New Employee Group: As determined by your Employer.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included. For your Dependents to be insured for these benefits, you must elect the Dependent insurance for yourself no later than 30 days after you become eligible.

A newborn child will be covered for the first 31 days of life even if you fail to enroll the child. If you enroll the child after the first 31 days and by the 60th day after his birth, coverage will be offered at an additional premium. Coverage for an adopted child will become effective from the date of placement in your home or from birth for the first 31 days even if you fail to enroll the child. However, if you enroll the adopted child between the 31st and 60th days after his birth or placement in your home, coverage will be offered at an additional premium.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

If notice is given within 60 days of the birth of the child, the insurer may not deny coverage for a child due to the failure of the insured to timely notify the insurer of the birth of the child.

HC-ELG326 03-21

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care

Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents. If you need assistance selecting your Primary Care Physician, please visit our website at www.cigna.com or call the number on the back of your ID Card.

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

You and your Dependents are allowed direct access to Participating Physicians for covered services. Even if you select a Primary Care Physician, there is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Physician of your choice, including Participating Specialist Physicians, for covered services.

Changing Primary Care Physicians

You may request a transfer from one Primary Care Physician to another by visiting our website at www.cigna.com or calling the number on the back of your ID Card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

Direct Access For Mental Health and Substance Use Disorder Services

You are allowed direct access to a licensed/certified Participating Provider for covered Mental Health and Substance Use Disorder Services. There is no requirement to obtain an authorization of care from your Primary Care Physician for individual or group therapy visits to the Participating Provider of your choice for Mental Health and Substance Use Disorder.

Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus Medical Benefits, you and your Dependents 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 Covered Expenses that an insured person is required to pay under the plan in addition to the Deductible, if any.

Copayments/Deductibles

Copayments are amounts to be paid by you or your Dependent for covered services. Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this plan. 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.

Out-of-Pocket Expenses - For In-Network Charges Only

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, 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-Pocket Expenses - For Out-of-Network Charges Only

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%:

- Coinsurance.
- Plan Deductible.

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Non-compliance penalties.
- Any copayments and/or benefit deductibles.
- Provider charges in excess of the Maximum Reimbursable Charge.

Open Access Plus Medical Benefits

The Schedule

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums will cross-accumulate (that is, In-Network will accumulate to Out-of-Network and Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) also cross-accumulate between In- and Out-of-Network unless otherwise noted.

Multiple Surgical Reduction

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

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

Out-of-Network Charges for Certain Services (Non-Emergency)

Charges for services furnished by an Out-of-Network provider in an In-Network facility while you are receiving In-Network services at that In-Network facility: (i) are payable at the In-Network cost-sharing level; and (ii) the allowable amount used to determine the Plan's benefit payment is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.
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.

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, other facility as required by Florida law, 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. If the provider and Cigna cannot agree on an allowable amount, Cigna or the provider may request dispute resolution pursuant to Florida law. Out-of-Network providers who are subject to Florida law may not attempt to collect from you any amount in excess of the allowable amount.
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.

Open Access Plus Medical Benefits

The Schedule

Out-of-Network Air Ambulance Services Charges

1. Covered air ambulance services are payable 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 air ambulance services rendered by an Out-of-Network provider is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.

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.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	Unlimited
The Percentage of Covered Expenses the Plan Pays	90%	70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maximum Reimbursable Charge The Maximum Reimbursable Charge for Out-of-Network services other than those described in The Schedule sections Out-of-Network Charges for Certain Services and Out-of-Network Emergency Services Charges and Out-of-Network Air Ambulance Services Charges is determined based on the lesser of the provider's normal charge for a similar service or supply; or the amount agreed to by the Out-of-Network provider and Cigna, or a policyholder-selected 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 state, regional or national charge data may be used. 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.	Not Applicable	90th Percentile
Calendar Year Deductible		
Individual	$1,000 per person	$2,000 per person
Family Maximum	$2,000 per family	$4,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Combined Medical/Pharmacy Calendar Year Deductible		
Combined Medical/Pharmacy Deductible: includes retail and home delivery drugs	Yes	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Deductible	Yes	Yes
Out-of-Pocket Maximum		
Individual	$2,000 per person	$4,000 per person
Family Maximum	$4,000 per family	$8,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		
Combined Medical/Pharmacy Out-of-Pocket Maximum		
Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery drugs	Yes	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	Yes	Yes

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Consultant and Referral Physician's Services		
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna on an In-Network basis. Out-of-Network OB/GYN providers will be considered a Specialist.		
Surgery Performed in the Physician's Office		
Primary Care Physician	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Second Opinion Consultations (provided on a voluntary basis)		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Allergy Treatment/Injections		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Allergy Serum (dispensed by the Physician in the office)		
Primary Care Physician	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Convenience Care Clinic (includes any related lab and x-ray services and surgery)	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Virtual Care **Dedicated Virtual Providers** Dedicated virtual care services may be provided by MDLIVE, a Cigna affiliate. Services available through contracted virtual providers as medically appropriate. **Notes:** • Primary Care cost share applies to routine care. Virtual wellness screenings are payable under preventive care. • MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below). • Lab services supporting a virtual visit must be obtained through dedicated labs.		
MDLIVE Urgent Care Services	$50 per visit copay, then 100%	In-Network coverage only
MDLIVE Primary Care Services	$20 per visit copay, then 100%	In-Network coverage only
MDLIVE Specialty Care Services	$40 per visit copay, then 100%	In-Network coverage only
Virtual Physician Services Services available through Physicians as medically appropriate. **Note:** Preventive services covered at the preventive level.		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Preventive Care		
Routine Preventive Care (for children through age 15)		
Primary Care Physician's Office Visit	100%	70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	100%	70% of the Maximum Reimbursable Charge
Immunizations (for children through age 15)		
Primary Care Physician's Office Visit	100%	70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	100%	70% of the Maximum Reimbursable Charge
Routine Preventive Care (for ages 16 and over)		
Primary Care Physician's Office Visit	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Immunizations (for ages 16 and over)		
Primary Care Physician's Office Visit	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Mammograms, PSA, PAP Smear		
Preventive Care Related Services (i.e. "routine" services)	100%	Subject to the plan's x-ray benefit & lab benefit; based on place of service
Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray benefit & lab benefit; based on place of service	Subject to the plan's x-ray benefit & lab benefit; based on place of service

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Women's Surgical Sterilization Procedures (e.g. tubal ligation) Excludes reversals		
Primary Care Physician's Office Visit	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services	100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Hospital – Facility Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Hospital Physician's Visits/Consultations	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services Surgeon Radiologist, Pathologist, Anesthesiologist	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services Surgeon Radiologist, Pathologist, Anesthesiologist	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Services		
Urgent Care Facility or Outpatient Facility Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the UC visit.	$50 per visit copay, then plan deductible, then 90%	$50 per visit copay, then plan deductible, then 90% of the Maximum Reimbursable Charge
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the UC visit	$50 per visit copay, then plan deductible, then 90%	$50 per visit copay, then plan deductible, then 90% of the Maximum Reimbursable Charge
Emergency Services		
Hospital Emergency Room Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.	$100 per visit copay (waived if admitted), then plan deductible, then 90%	$100 per visit copay (waived if admitted), then plan deductible, then 90%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER visit	$100 per visit copay (waived if admitted), then plan deductible, then 90%	$100 per visit copay (waived if admitted), then plan deductible, then 90%
Air Ambulance	Plan deductible, then 90%	Plan deductible, then 90%
Ambulance	Plan deductible, then 90%	Plan deductible, then 90% of the Maximum Reimbursable Charge
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Laboratory Services		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 90% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 90% of the Maximum Reimbursable Charge
Outpatient Hospital Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Independent Lab Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Radiology Services		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Hospital Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Therapy Services Calendar Year Maximum: Unlimited Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy		
Primary Care Physician's Office Visit	$20 per visit copay*, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay*, then 100% ***Note:** Outpatient Therapy Services copay applies, regardless of place of service, including the home.	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Spinal Manipulation Services Calendar Year Maximum: 20 days		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Home Health Care Services Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Hospice Inpatient Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Services (same coinsurance level as Home Health Care Services)	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Bereavement Counseling Services provided as part of Hospice Care		
Inpatient	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Medical Pharmaceuticals Inpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Cigna Pathwell Specialty Medical Pharmaceuticals	Cigna Pathwell Specialty Network provider: $20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Other Medical Pharmaceuticals	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary. Gene therapy must be received at an In-Network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other In-Network facilities is not covered.		
Gene Therapy Product	Covered same as Medical Pharmaceuticals	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Hospital Facility Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Travel Maximum: $10,000 per episode of gene therapy	100% (available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy)	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Advanced Cellular Therapy Includes prior authorized advanced cellular therapy products and related services when Medically Necessary.		
Advanced Cellular Therapy Product	Covered Same as Medical Pharmaceuticals	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Advanced Cellular Therapy Travel Maximum: $10,000 per episode of advanced cellular therapy (Available only for travel when prior authorized to receive advanced cellular therapy from a provider located more than 60 miles of your primary residence and is contracted with Cigna for the specific advanced cellular therapy product and related services.)	100%	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services		
Initial Visit to Confirm Pregnancy		
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna on an In-Network basis. Out-of-Network OB/GYN providers will be considered a Specialist.		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Delivery - Facility (Inpatient Hospital, Birthing Center)	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Abortion Includes elective and non-elective procedures		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Infertility Treatment Services Not Covered include: • 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 means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not Covered	Not Covered

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Transplant Services and Related Specialty Care Includes all medically appropriate, non-experimental transplants		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	100% at Lifesource center, otherwise plan deductible, then 90%	Plan deductible, then 50% of the Maximum Reimbursable Charge up to transplant maximum
Inpatient Professional Services	100% at Lifesource center, otherwise plan deductible, then 90%	Plan deductible, then 50% of the Maximum Reimbursable Charge up to specific organ transplant maximum: Heart - $150,000 Liver - $230,000 Bone Marrow - $130,000 Heart/Lung - $185,000 Lung - $185,000 Pancreas - $50,000 Kidney - $80,000 Kidney/Pancreas - $80,000
Lifetime Travel Maximum: $10,000 per transplant	100%	100% of the Maximum Reimbursable Charge
Durable Medical Equipment Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Dialysis Services		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Home Setting	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
External Prosthetic Appliances Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Diabetic Equipment Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Nutritional Counseling Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of diabetes and/or to mental health and substance use disorder conditions.		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Genetic Counseling Calendar Year Maximum: 3 visits per person for Genetic Counseling for both pre- and post-genetic testing; however, the 3 visit limit will not apply to Mental Health and Substance Use Disorder conditions.		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Dental Care Limited to charges made for a continuous course of dental treatment for an Injury to teeth.		
Primary Care Physician's Office Visit	$20 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Specialty Care Physician's Office Visit	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Facility	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Inpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient Professional Services	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		
Mental Health		
Inpatient Includes Acute Inpatient and Residential Treatment Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient		
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Dedicated Virtual Providers MDLIVE Behavioral Services	$40 per visit copay, then 100%	In-Network coverage only
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Substance Use Disorder		
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Outpatient		
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited	$40 per visit copay, then 100%	Plan deductible, then 70% of the Maximum Reimbursable Charge
Dedicated Virtual Providers MDLIVE Behavioral Services	$40 per visit copay, then 100%	In-Network coverage only
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 70% of the Maximum Reimbursable Charge

Open Access Plus Medical Benefits

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

- as a registered bed patient, except for 48/96 hour maternity stays;
- for Mental Health or Substance Use Disorder Residential Treatment Services.

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

Covered Expenses incurred will be reduced by 50% for Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will be reduced by 50%:

- Hospital charges for Room and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

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

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Certification Requirements – Out-of-Network

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

Covered Expenses incurred will be reduced by 50% for charges made for any outpatient diagnostic testing or outpatient procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will be reduced by 50% for charges made for outpatient diagnostic testing or outpatient procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Home Health Care Services.
- Medical Pharmaceuticals.
- Radiation therapy.

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Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays.

- inpatient services at any participating Other Health Care Facility.
- residential treatment.
- outpatient facility services.
- partial hospitalization.
- advanced radiological imaging.
- non-emergency Ambulance.
- certain Medical Pharmaceuticals.
- home health care services.
- radiation therapy.
- transplant services.

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Covered Expenses

The term Covered Expenses means 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.

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.

Any applicable Copayments, Deductibles or limits are shown in The Schedule.

Covered Expenses

- charges for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital, subject to the limits as shown in The Schedule.
- charges for inpatient Room and Board and other Necessary Services and Supplies made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility as shown in The Schedule.
- charges for licensed ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
- charges for outpatient medical care and treatment received at a Hospital.
- charges for outpatient medical care and treatment received at a Free-Standing Surgical Facility.
- charges for Emergency Services.
- charges for Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse for professional nursing service.
- charges made for anesthetics, including, but not limited to supplies and their administration.
- charges for diagnostic x-ray.
- charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.
- charges for chemotherapy.
- charges for blood transfusions.
- charges for oxygen and other gases and their administration.
- charges made for Medically Necessary foot care for diabetes, peripheral neuropathies, and peripheral vascular disease.
- charges made for screening prostate-specific antigen (PSA) testing.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges for men’s family planning, counseling, testing and sterilization (e.g. vasectomies), excluding reversals.
- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: a baseline mammogram for women ages 35 through 39; a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; a mammogram every year for women age 50 and over; and one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician’s recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.
- charges made for preventive care services as defined by recommendations from the following:
  - the U.S. Preventive Services Task Force (A and B recommendations);
  - the Advisory Committee on Immunization Practices (ACIP) for immunizations;
  - the American Academy of Pediatrics’ Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;

- the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
- with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.

Detailed information is available at www.healthcare.gov. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.

- charges made for diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint. Appliances and non-surgical treatment including for orthodontia are not covered.
- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.
- charges for general anesthesia and hospitalization services for dental procedures for an individual who is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.
- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.
- charges made for 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. Services provided to you by a certified nurse-midwife or a licensed midwife, in a home setting or in a licensed birthing center. Coverage for a mother and her newborn child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. Post delivery care for a mother and her newborn shall be covered. Post delivery care includes: a postpartum assessment and newborn assessment, which can be provided at the hospital, the attending Physician's office, and outpatient maternity center or in the home by an Other Health Care Professional trained in mother and newborn care. The services may include physical assessment of the newborn and mother, and the performance of any clinical tests and immunizations in keeping with prevailing medical standards.
- charges for coverage for diagnosis and treatment of autism spectrum disorder to include autistic disorder, Asperger's Syndrome and pervasive developmental disorder not otherwise specified, when prescribed by a treating Physician. Treatment includes well-baby and well-child screening for diagnosis and treatment through speech therapy, occupational therapy, physical therapy and applied behavior analysis.
- charges for the treatment of Down syndrome through speech therapy, occupational therapy, physical therapy and applied behavioral analysis. Includes habilitative and rehabilitative services.
- charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: have vertebral abnormalities; are receiving long-term glucocorticoid (steroid) therapy; have primary hyperparathyroidism; have a family history of osteoporosis; and/or are estrogen-deficient individuals who are at clinical risk for osteoporosis.
- charges for or in connection with a bone marrow transplant when recommended by a Physician and deemed acceptable by the appropriate oncological specialty. This treatment cannot be considered experimental under the rules of the Secretary of Health and Rehabilitative Services. Please call your Claims Office prior to receiving any treatment in order to determine your benefits.
- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be Medically Necessary by the Physician and in consultation with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.
- charges for newborn and infant hearing screening as well as any medically necessary follow-up evaluations leading to diagnosis and subsequent medically necessary treatment of a diagnosed hearing impairment.
- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.
- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage on oral contraceptives.
- charges for the coverage of child health supervision services from birth to age 16. Child health supervision services are physician-delivered or supervised services that include periodic visits which include a history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests.

Convenience Care Clinic

Convenience Care Clinics provide for common ailments and routine services, including but not limited to, strep throat, ear infections or pink eye, immunizations and flu shots.

Virtual Care: Medical

Dedicated Virtual Providers

Includes charges for the delivery of real-time medical and health-related services, consultations, and remote monitoring by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.

Includes charges for the delivery of mental health and substance use disorder-related services, consultations, and remote monitoring by dedicated virtual providers as appropriate through audio, video and secure internet-based technologies.

Virtual Physician Services

Includes charges for the delivery of real-time medical and health-related services, consultations, and remote monitoring as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.

Includes charges for the delivery of real-time mental health and substance use disorder consultations and services, via secure telecommunications technologies that shall include video capability, telephone and internet, when such consultations and services are delivered by a behavioral provider and are similar to office visit services provided in a face-to-face setting.

Nutritional Counseling

Charges for counseling when diet is a part of the medical management of a medical or behavioral condition.

Enteral Nutrition

Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism (e.g., disorders of amino acid or organic acid metabolism).

Internal Prosthetic/Medical Appliances

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

Home Health Care Services

Charges for skilled care provided by certain health care providers during a visit to the home, when the home is determined to be a medically appropriate setting for the services. A visit is defined as a period of 2 hours or less. Home Health Care Services are subject to a maximum of 16 hours in total per day.

Home Health Care Services are covered when skilled care is required under any of the following conditions:

- the required skilled care cannot be obtained in an outpatient facility.
- confinement in a Hospital or Other Health Care Facility is not required.
- the patient's home is determined by Cigna to be the most medically appropriate place to receive specific services.

Covered services include:

- skilled nursing services provided by a Registered Nurse (RN); Licensed Practical Nurse (LPN); Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse (APRN).
- services provided by health care providers such as a physical therapist; occupational therapist or speech therapist.
- services of a home health aide when provided in direct support of those Nurses and health care providers.
- necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.

Note: Physical, occupational, and other Outpatient Therapy Services provided in the home are covered under the Outpatient Therapy Services benefit shown in The Schedule.

The following are excluded from coverage:

- services provided by a person who is a member of the patient's family, even when that person is a health care provider.
- services provided by a person who normally resides in the patient's house, even when that person is a health care provider.
- non-skilled care, Custodial Services, and assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other services; self-care activities; homemaker services; and services primarily for rest, domiciliary or convalescent care.

Home Health Care Services, for a patient who is dependent upon others for non-skilled care and/or Custodial Services, is provided only when there is a family member or caregiver present in the home at the time of the health care visit to provide the non-skilled care and/or Custodial Services.

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Hospice Care Services

Charges for services for a person diagnosed with advanced Illness (having a life expectancy of twelve or fewer months). Services provided by a Hospice Care Program are available to those who have ceased treatment and to those continuing to receive curative treatment and therapies.

A Hospice Care Program rendered by a Hospice Facility or Hospital includes services:

- by a Hospice Facility for Room and Board and Services and Supplies;
- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies.

A Hospice Care Program rendered by an Other Health Care Facility or in the Home includes services:

- part-time or intermittent nursing care by or under the supervision of a Nurse;
- part-time or intermittent services of an Other Health Professional;
- physical, occupational and speech therapy;
- medical supplies;
- drugs and medicines lawfully dispensed only on the written prescription of a Physician;
- 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:

- 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;
- services for any period when you or your Dependent is not under the care of a Physician;
- services or supplies not listed in the Hospice Care Program;
- to the extent that any other benefits are payable for those expenses under the policy;
- services or supplies that are primarily to aid you or your Dependent in daily living.

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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 of 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

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include 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 you or your Dependent 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 you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance 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 you or your Dependent 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.

Exclusions

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

- 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.

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when

required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person'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 Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, ventilators, insulin pumps and wheel chairs.

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

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers and air purifiers.
- **Other Equipment:** centrifuges, needleless injectors, heat lamps, heating pads, cryounits, cryotherapy machines, ultraviolet cabinets that emit Ultraviolet A (UVA) rays, sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment and diathermy machines.

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External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect.

External prosthetic appliances and devices 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:

- limb prostheses;
- terminal devices such as hands or hooks;
- speech prostheses; and
- facial 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:

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

The following are specifically excluded orthoses and orthotic devices:

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

- non-foot 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 required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- replacement due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited as follows:

- no more than once every 24 months for persons 19 years of age and older.
- no more than once every 12 months for persons 18 years of age and under.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements for external prosthetic devices;
- microprocessor controlled prostheses and orthoses; and
- myoelectric prostheses and orthoses.

Outpatient Therapy Services

Charges for the following therapy services when provided as part of a program of treatment: **Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy**

Cardiac Rehabilitation

- Charges for Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

  Phase III and Phase IV cardiac rehabilitation are not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

Spinal Manipulation Services

- Charges for diagnostic and treatment services utilized in an office setting by spinal manipulation Physicians. Spinal manipulation 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. For these services you have direct access to qualified spinal manipulation Physicians.

Coverage is provided when Medically Necessary in the most medically appropriate setting to:

- Restore function (called rehabilitative):
  - To restore function that has been impaired or lost.
  - To reduce pain as a result of Sickness, Injury, or loss of a body part.
- Improve, adapt or attain function (sometimes called habilitative):
  - To improve, adapt or attain function that has been impaired or was never achieved as a result of congenital abnormality (birth defect).
  - To improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions. Includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.

Coverage is provided as part of a program of treatment when the following criteria are met:

- The individual’s condition has the potential to improve or is improving in response to therapy, and maximum improvement is yet to be attained.
- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The therapy is provided by, or under the direct supervision of, a licensed health care professional acting within the scope of the license.
- The therapy is Medically Necessary and medically appropriate for the diagnosed condition.

Coverage for occupational therapy is provided only for purposes of enabling individuals to perform the activities of daily living after an Injury or Sickness.

Therapy services that are not covered include:

- sensory integration therapy,
- treatment of dyslexia,
- maintenance or preventive treatment provided to prevent recurrence or to maintain the patient's current status,
- charges for Spinal Manipulation Care not provided in an office setting,
- vitamin therapy.

Coverage is administered according to the following:

- Multiple therapy services provided on the same day constitute one day of service for each therapy type.
- A separate Copayment applies to the services provided by each provider for each therapy type per day.

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Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and prosthetics, limited to the lowest cost alternative available that meets prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is 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. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

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Transplant Services and Related Specialty Care

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. Implantation procedures for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO), ventricular assist device (VAD), and intra-aortic balloon pump (IABP) are also covered.

- All transplant services and related specialty care services, other than cornea transplants, are covered when received at Cigna LifeSOURCE Transplant Network® facilities.
- Transplant services and related specialty care services received at Participating Provider facilities specifically contracted with Cigna for those transplant services and related specialty care services, other than Cigna LifeSOURCE Transplant Network® facilities, are payable at the In-Network level.
- Transplant services and related specialty care services received at any other facility, including non-Participating Provider facilities and Participating Provider facilities not specifically contracted with Cigna for transplant services and related specialty care services, are covered at the Out-of-Network level.
- Cornea transplants received at a facility that is specifically contracted with Cigna for this type of transplant are payable at the In-Network level.

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 hospitalization and surgery necessary for removal of an organ and transportation of a live donor (refer to Transplant and Related Specialty Care Travel Services). 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 and Related Specialty Care Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations:

- Transplant and related specialty care travel benefits are not available for cornea transplants.
- Benefits for transportation and lodging are available to the recipient of a pre-approved organ/tissue transplant and/or related specialty care 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 designated Cigna LifeSOURCE Transplant Network® facility (including charges for a rental car used during a period of care at the Cigna designated LifeSOURCE Transplant Network® facility); and lodging while at, or traveling to and from the Cigna LifeSOURCE Transplant Network® facility.
- In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver 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 for Transplant Services and Related Specialty Care, and for Transplant and Related Specialty Care Travel Services are only available when the covered person 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 transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant; the transplant recipient's plan would cover all donor costs.

HC-COV1325 01-24

Advanced Cellular Therapy

Charges for advanced cellular therapy products and services directly related to their administration are covered when Medically Necessary. Coverage includes the cost of the advanced cellular therapy product; medical, surgical, and facility services directly related to administration of the advanced cellular therapy product, and professional services.

Cigna determines which U.S. Food and Drug Administration (FDA) approved products are in the category of advanced cellular therapy, based on the nature of the treatment and how it is manufactured, distributed and administered. An example of advanced cellular therapy is chimeric antigen receptor (CAR) T-cell therapy that redirects a person's T cells to recognize and kill a specific type of cancer cell.

Advanced cellular therapy products and their administration are covered at the in-network benefit level when prior authorized to be received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services. Advanced cellular therapy products and their administration received from a provider that is not contracted with Cigna for the specific advanced cellular therapy product and related services are covered at the out-of-network benefit level when prior authorized.

Advanced Cellular Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized advanced cellular therapy product are covered, subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when:

- you are the recipient of a prior authorized advanced cellular therapy product;
- the term recipient is defined to include a person receiving prior authorized advanced cellular therapy related services during any of the following: evaluation, candidacy, event, or post care;
- the advanced cellular therapy products and services directly related to their administration are received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services; and
- the provider is not available within a 60 mile radius of your primary home residence.

Travel expenses for the person receiving the advanced cellular therapy include charges for: transportation to and from the advanced cellular therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The

term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver 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 mile radius of your primary home residence; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

HC-COV1326 01-24

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that may be 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 that, because of their characteristics as determined by Cigna, require a qualified licensed health care professional to administer or directly supervise administration.

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 coverage, the covered person may be required to try a specific Medical Pharmaceutical before trying others. Medical Pharmaceuticals administered in an Inpatient facility are reviewed per Inpatient review guidelines.

Cigna determines the utilization management requirements and other coverage conditions that apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to:

- Clinical factors, which may include but are not limited to Cigna's evaluations of the site of care and the relative safety or relative efficacy of Medical Pharmaceuticals.
- Economic factors, which may include but are not limited to the cost of the Medical Pharmaceutical and assessments of cost effectiveness after rebates.

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.

Certain Medical Pharmaceuticals that are used for treatment of complex chronic conditions, are high cost, and are administered and handled in a specialized manner may be subject to additional coverage criteria or require administration by a participating provider in the network for the Cigna Pathwell Specialty Network. Cigna determines which injections, infusions, and implantable drugs are subject to these criteria and requirements.

The Cigna Pathwell Specialty Network includes but is not limited to contracted physician offices, ambulatory infusion centers, home and outpatient hospital infusion centers, and contracted specialty pharmacies. When the Cigna Pathwell Specialty Network cannot meet the clinical needs of the customer as determined by Cigna, exceptions are considered and approved when appropriate.

A complete list of those Medical Pharmaceuticals subject to additional coverage criteria or that require administration by a participating provider in the Cigna Pathwell Specialty Network is available at www.cigna.com/PathwellSpecialty.

The following are not covered under the plan, including but not limited to:

- Medical Pharmaceutical regimens that have a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s);
- Medical Pharmaceuticals newly approved by the Food & Drug Administration (FDA) up to the first 180 days following its market launch;
- Medical Pharmaceutical regimens for which there is an appropriate lower cost alternative for treatment.

In the event a covered Medical Pharmaceutical is not clinically appropriate, Cigna makes available an exception process to allow for access to non-covered drugs when Medically Necessary.

Cigna may consider certain Medical Pharmaceutical regimens as preferred when they are clinically effective treatments and the most cost effective. Preferred regimens are covered unless the covered person is not a candidate for the regimen and a Medical Necessity coverage exception is obtained.

HC-COV1186 01-23

Gene Therapy

Charges for gene therapy products and services directly related to their administration are covered when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.

- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when prior authorized to be received at In-Network facilities specifically contracted with Cigna for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered.

Gene Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy; and when the gene therapy products and services directly related to their administration are received at a participating In-Network facility specifically contracted with Cigna for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver 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.

HC-COV886 01-20

Clinical Trials

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

- 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; or
- the individual provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered.

The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that meets **any** of the following criteria:

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Health Care Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
  - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
- any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:
  - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and

- the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA);
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The plan does not cover any of the following services associated with a clinical trial:

- services that are not considered routine patient care costs and services, including the following:
  - the investigational drug, device, item, or service that is provided solely to satisfy data collection and analysis needs;
  - an item or service that is not used in the direct clinical management of the individual;
  - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- an item or service provided by the research sponsors free of charge for any person enrolled in the trial.
- travel and transportation expenses, unless otherwise covered under the plan, including but not limited to the following:
  - fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train;
  - mileage reimbursement for driving a personal vehicle;
  - lodging;
  - meals.
- routine patient costs obtained out-of-network when Out-of-Network benefits do not exist under the plan.

Examples of routine patient care costs and services include:

- radiological services.
- laboratory services.
- intravenous therapy.
- anesthesia services.
- Physician services.
- office services.
- Hospital services.
- Room and Board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

Clinical trials conducted by Out-of-Network providers will be covered only when the following conditions are met:

- In-Network providers are not participating in the clinical trial; or
- the clinical trial is conducted outside the individual's state of residence.

HC-COV1016 01-21

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by Cigna only to a person who:

- resides in a state that requires offering a conversion policy,
- is Entitled to Convert, and
- applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled to Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased but only if:

- you are not eligible for other individual insurance coverage on a guaranteed issue basis.
- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

If you retire, you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for other individual insurance coverage on a guaranteed issue basis, is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy

If you reside in a state that requires the offering of a conversion policy, the Converted Policy will be one of Cigna's current conversion policy offerings available in the state where you reside, as determined based upon Cigna's rules.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are Entitled to Convert, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

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Prescription Drug Benefits
The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a Deductible, Copayment or Coinsurance requirement for Covered Expenses for Prescription Drug Products.

You and your Dependents will pay 100% of the cost of any Prescription Drug Product excluded from coverage under this plan. The amount you and your Dependent pays for any excluded Prescription Drug Product to the dispensing Pharmacy, will not count towards your Deductible, if any, or Out-of-Pocket Maximum.

Coinsurance

The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.

Oral Chemotherapy Medication

Prescription oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered at participating pharmacies at 100% with no deductible and if applicable at non-participating pharmacies, is covered at the lower of the pharmacy cost share for oral chemotherapy medication or the out of network medical cost share for injectable/IV chemotherapy.

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY

Non-PPACA Preventive Medications

Non-PPACA Preventive Medications used to prevent any of the following medical conditions and that are dispensed by a Pharmacy are not subject to the Deductible:

- hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency
- smoking cessation

Maintenance Drug Products

Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Pharmacy or home delivery Pharmacy.

Certain Preventive Care Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required.

Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy**
Tier 1 Generic Drugs on the Prescription Drug List	50%	50%

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	50%	50%
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	50%	50%
Prescription Drug Products at Retail Designated Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Designated Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Designated Pharmacy**
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill.		
Note: In this context, a retail Designated Pharmacy is a retail Network Pharmacy that has contracted with Cigna for dispensing of covered Prescription Drug Products, including Maintenance Drug Products, in 90-day supplies per Prescription Order or Refill.		
Tier 1 Generic Drugs on the Prescription Drug List	50%	50%
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	50%	50%
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	50%	50%
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy**
Tier 1 Generic Drugs on the Prescription Drug List	50%	50%
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	50%	50%

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	50%	50%

Prescription Drug Benefits

Covered Expenses

Your plan provides benefits for Prescription Drug Products on the Prescription Drug List dispensed by a Pharmacy. Details regarding your plan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations, and Exclusions are provided below and/or are shown in The Schedule.

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule. Your benefits may vary depending on which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

Coverage under your plan's Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered pursuant to the, as applicable, Copayment or Coinsurance for the Prescription Drug Product when dispensed by a Network Pharmacy.

Prescription Drug List Management

Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. Determination of inclusion of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and utilization management requirements or other coverage conditions are based on a number of factors which may include, 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 the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product 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 status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). Please access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

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Limitations

Your plan includes a Brand Drug for Generic Drug dispensing program. This program allows certain Brand Drugs to be dispensed in place of the Therapeutic Equivalent Generic Drug at the time your Prescription Order or Refill is processed by a participating Pharmacy. Brand Drug for Generic Drug substitution will occur only for certain Brand Drugs included in the program. When this substitution program is applied, the participating Pharmacy will dispense the Brand Drug to you in place of the available Generic Drug. You will be responsible for payment of only a Generic Drug Copayment and/or Coinsurance, after satisfying your Deductible, if any.

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product 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 Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products 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 us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product 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 Product. The length of the authorization may depend on the diagnosis and the Prescription Drug Product. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product 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 Product 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 Product should be covered.

Step Therapy

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

Supply Limits

Benefits for Prescription Drug Products 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 Product 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 Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Specialty Prescription Drug Products

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

Designated Pharmacies

If you require certain Prescription Drug Products, including Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you may receive reduced or no coverage for the Prescription Drug Product. Refer to The Schedule for further information.

New Prescription Drug Products

New Prescription Drug Products may or may not be placed on a Prescription Drug List tier upon market entry. Cigna will use reasonable efforts to make a tier placement decision for a New Prescription Drug Product within six months of its market availability. Cigna's tier placement decision shall be based on consideration of, without limitation, the P&T Committee's clinical review of the New Prescription Drug Product and economic factors. If a New Prescription Drug Product 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 Product shall be covered at the applicable coverage tier as set forth in The Schedule.

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule, as well as any limitations or exclusions set forth in this plan. Please refer to

The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

Coinsurance

Your plan requires that you pay a Coinsurance amount for covered Prescription Drug Products as set forth in The Schedule. After satisfying any applicable annual Deductible set forth in The Schedule, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy and that is subject to a Coinsurance requirement will be the lowest of the following amounts:

- the amount that results from applying the applicable Coinsurance percentage set forth in The Schedule to the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

Payments at Non-Network Pharmacies

Any reimbursement due to you under this plan for a covered Prescription Drug Product dispensed by a non-Network Pharmacy may be determined by applying the Deductible, if any, and/or non-Network Pharmacy Coinsurance amount set forth in The Schedule to the average wholesale price (or "AWP"), or other benchmark price Cigna applies, for a Prescription Drug Product dispensed by a non-Network Pharmacy. Your reimbursement, if any, for a covered Prescription Drug Product dispensed by a non-Network Pharmacy will never exceed the average wholesale price (or other benchmark price applied by Cigna) for the Prescription Drug Product.

When a treatment regimen contains more than one type of Prescription Drug Products that are packaged together for your or your Dependent's convenience, any applicable Copayment or Coinsurance may apply to each Prescription Drug Product.

You will need to obtain prior approval from Cigna or its Review Organization for any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded. If Cigna or its Review Organization approves coverage for the Prescription Drug Product because it meets the applicable coverage exception criteria, the Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

The amount you or your Dependent pays for any excluded Prescription Drug Product 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 Product or other product.

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Exclusions

Coverage exclusions listed under the "Exclusions, Expenses Not Covered and General Limitations" section also apply to benefits for Prescription Drug Products. In addition, the exclusions listed below apply to benefits for Prescription Drug Products. When an exclusion or limitation applies to only certain Prescription Drug Products, you can access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

- coverage for Prescription Drug Products 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 Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products dispensed outside the jurisdiction of the United States, except as required for emergency or Urgent Care treatment.
- Prescription Drug Products 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 Drug Products 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 Drug Products.
- 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 or anti-aging purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth and fade cream products.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.

- any ingredient(s) in a compounded Prescription Drug Product 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 Product.
- certain Prescription Drug Products 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 Product 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.
- medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions unless specifically identified on the Prescription Drug List.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- medications that are experimental investigational or unproven as described under the "General Exclusion and Limitations" section of your plan's certificate.

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Reimbursement/Filing a Claim

Retail Pharmacy

When you or your Dependents purchase your Prescription Drug Products through a Network Pharmacy, you pay any applicable Copayment, Coinsurance, or Deductible shown in The Schedule at the time of purchase. You do not need to file a claim form for a Prescription Drug Product obtained at a Network Pharmacy unless you pay the full cost of a Prescription Drug Product at a Network Pharmacy and later seek reimbursement for the Prescription Drug Product under the plan. For example, if you must pay the full cost of a Prescription Drug Product to the retail Network Pharmacy because you did not have your ID card, then you must submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. If, under this example, your payment to the retail Network Pharmacy for the covered Prescription Drug Product exceeds any applicable copay, then you will be reimbursed the difference, if any, between the applicable copay and the Prescription Drug Charge for the Prescription Drug Product.

If you obtain a covered Prescription Drug Product dispensed by a non-Network Pharmacy, then you must pay the non-Network Pharmacy for the Prescription Drug Product and then submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. You can obtain a claim form through the website shown on your ID card or by calling member services at the telephone number on your ID card.

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- charges which you are not obligated to pay and/or for which you are not billed. This exclusion includes, but is not limited to:
  - any instance where Cigna determines that a provider or Pharmacy did not bill you for or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.

- charges of a non-Participating Provider who has agreed to charge you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.

In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:

- require you and/or any provider or Pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna,
- deny the payment of benefits in connection with the Covered Expense regardless of whether the provider or the Pharmacy represents that you remain responsible for any amounts that your plan does not cover, 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 provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover.
- charges or payment for healthcare-related services that violate state or federal law.

- 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 or Biologic therapies or devices that are determined by the utilization review Physician to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed.
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

  The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed, and is recognized for the treatment of cancer in any one of the following: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; U.S. Pharmacopeia Drug Information; or a U.S. peer-reviewed national professional journal.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for a continuous course of dental treatment for an Injury to teeth are also covered. Also, facility charges and charges for general anesthesia or deep sedation which cannot be administered in a dental office are covered when Medically Necessary.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- 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, unless otherwise covered under this plan.

- court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of sperm, eggs or embryos are also excluded from coverage.
- reversal of male and female voluntary sterilization procedures.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy and premature ejaculation.
- medical and Hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under this plan.
- non-medical counseling and/or ancillary services including Custodial Services, educational 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.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Care Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Care Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with non-verbal communications, including communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames, contact lenses and associated services (exams and fittings) except the initial set after treatment of keratoconus or following cataract surgery.
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- acupuncture.
- all noninjectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered.
- membership costs and fees associated with health clubs, weight loss programs or smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- health and beauty aids, cosmetics and dietary supplements.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.

- charges related to an Injury or Sickness payable under worker's compensation or similar laws.
- massage therapy.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- for any charges related to care provided through a public program, other than Medicaid.
- for charges which would not have been made if the person did not have coverage.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- for expenses for services, supplies, care, treatment, drugs or surgery that are not Medically Necessary.
- for charges made by any Physician or Other Health Professional who is a member of your family or your Dependent's family.
- for expenses incurred outside the United States other than expenses for Medically Necessary emergency or urgent care while temporarily traveling abroad.

HC-EXC528 01-24

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

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

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

The amount of charges considered for payment under the Plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and

one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

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

Reasonable Cash Value

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 by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee 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 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 an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, 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; and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

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

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all

Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare Plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 55 days of the request, the claim will be closed. If the requested information is subsequently received, the claim will be processed.

Coordination of Benefits with Medicare

If you, your spouse, or your Dependent are covered under this Plan and qualify for Medicare, federal law determines which Plan is the primary payer and which is the secondary payer. The primary payer always determines covered benefits first, without considering what any other coverage will pay. The secondary payer determines its coverage only after the Primary Plan has completed its determination.

When Medicare is the Primary Payer

Medicare will be the primary payer and this Plan will be the secondary payer, even if you don't elect to enroll in Medicare or you receive services from a provider who does not accept Medicare payments, in the following situations:

- COBRA or State Continuation: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to COBRA or state continuation of coverage.
- Retirement or Termination of Employment: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to your retirement or termination of employment.
- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has fewer than 100 employees.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has fewer than 20 employees.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan will be the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

When This Plan is the Primary Payer

This Plan will be the primary payer and Medicare will be the secondary payer in the following situations:

- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has 100 or more employees.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has 20 or more employees.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan is the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

IMPORTANT: If you, your spouse, or your Dependent do not elect to enroll in Medicare Parts A and/or B when first eligible, or you receive services from a provider who does not accept Medicare payments, this Plan will calculate payment based on what should have been paid by Medicare as the primary payer if the person had been enrolled or had received services from a provider who accepts Medicare payments. A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective.

Failure to Enroll in Medicare

If you, your spouse, or your Dependent do not enroll in Medicare Parts A and/or B during the person's initial Medicare enrollment period, or the person opts out of coverage, the person may be subject to Medicare late enrollment penalties, which can cause a delay in coverage and result in higher Medicare premiums when the person does enroll. It can also result in a reduction in coverage under Medicare Parts A and B. If you are planning to retire or terminate employment and you will be eligible for COBRA,

state Continuation, or retiree coverage under this Plan, you should enroll in Medicare before you terminate employment to avoid penalties and to receive the maximum coverage under Medicare. Please consult Medicare or the Social Security Administration for more information.

Assistance with Medicare Questions

For more information on Medicare's rules and regulations, contact Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. You may also contact the Social Security Administration toll-free at 1-800-772-1213, at www.ssa.gov, or call your local Social Security Administration office.

HC-COB275 01-21

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

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

Subrogation/Right of Reimbursement

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

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

Lien of the Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall 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.

- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

HC-SUB77 01-17

Payment of Benefits

Assignment and Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

You may, however, authorize Cigna to pay any healthcare benefits under this policy to a Participating or Non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or Non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Expenses directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or Non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a Non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the Non-Participating Provider.

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

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

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

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

Calculation of Covered Expenses

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

- the methodologies in the most recent edition of the Current Procedural terminology.

- the methodologies as reported by generally recognized professionals or publications.

HC-POB132 01-19

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date as determined by your Employer.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness for a period not longer than 12 months.

Dependents

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

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

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

Special Continuation of Medical Insurance For Dependents of Military Reservists

If your insurance ceases because you are called to active military duty in: the Florida National Guard; or the United States military reserves, you may elect to continue Dependent insurance. You must pay the required premiums to the Policyholder if you choose to continue Dependent insurance.

In no event will coverage be continued beyond the earliest of the following dates:

- the expiration of 30 days from the date the Employee's military service ends;
- the last day for which the required contribution for Dependent insurance has been made;
- the date the Dependent becomes eligible for insurance under another group policy. Coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is excluded from this provision;
- the date the Dependent becomes eligible for Medicare (this does not apply to Vision insurance);
- the date the group policy cancels;
- the date the Dependent ceases to be an eligible Dependent.

Reinstatement of Medical Insurance - Employees and Dependents

Upon completion of your active military duty in: the Florida National Guard; or the United States military reserves, you are entitled to the reinstatement of your insurance and that of your Dependents if continuation of Dependent insurance was not elected. Such reinstatement will be without the application of: any new waiting periods; or the Pre-existing Condition Limitation to any new condition that you or your Dependent may have developed during the period that coverage was interrupted due to active military duty.

Provisions Applicable to Reinstatement

- You must notify your Employer, before reporting for military duty, that you intend to return to Active Service with that Employer; and
- You must notify your Employer that you elect such reinstatement within 30 days after returning to Active Service with that Employer and pay any required premium.

Conversion Available Following Continuation

The provisions of the "Medical Conversion Privilege" section will apply when the insurance ceases.

HC-TRM131 01-18

Rescissions

Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

HC-TRM80 01-11

Medical Benefits Extension Upon Policy Cancellation

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

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date a succeeding carrier agrees to provide coverage without limitation for the disabling condition;
- the date you are no longer Totally Disabled;
- 12 months from the date the policy is canceled; or
- for pregnancy, until delivery.

Totally Disabled

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

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

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

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

HC-BEX42 04-11

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.

HC-FED1 10-10

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.

HC-FED4 10-10

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.

HC-FED96 04-17

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen 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)

Employee: The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through an Exchange (Marketplace) or the Employee seeks to enroll in a QHP through an Exchange 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 an Exchange for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

Family: A plan may allow an Employee to revoke family coverage midyear in order for family members ("related individuals") to enroll in a QHP through an Exchange (Marketplace). The related individual(s) must be eligible for a Special Enrollment Period to enroll in a QHP or seek to enroll in a QHP during the Marketplace's annual open enrollment period, and the disenrollment from the group plan corresponds to the intended enrollment of the individual(s) in a QHP for new coverage effective beginning no later than the day immediately following the last day of the original coverage. If the Employee does not enroll in a QHP, the Employee must select self-only coverage or family coverage including one or more already-covered individuals.

HC-FED111 01-23

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.

HC-FED67 09-14

Coverage for Maternity Hospital Stay

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

Please review this Plan for further details on the specific coverage available to you and your Dependents.

HC-FED11 10-10

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.

HC-FED12 10-10

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.

HC-FED13 10-10

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.

HC-FED93 10-17

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.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan 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.

HC-FED18 10-10

Claim Determination Procedures under ERISA

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 postservice basis, as described below:

Certain services require prior authorization in order to be covered. The Certificate 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 Certificate, 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 Certificate, in your provider's network participation documents as applicable, and in the determination notices.

Note: An oral statement made to you by a representative of Cigna or its designee that indicates, for example, a particular service is a Covered Expense, is authorized for coverage by the plan, or that you are eligible for coverage is not a guarantee that you will receive benefits for services under this plan. Cigna will make a benefit determination after a claim is received from you or your authorized representative, and the benefit determination will be based on, your eligibility as of the date services were rendered to you and the terms and conditions of the plan in effect as of the date services were rendered to you.

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 attempts to request a preservice determination, but 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.

Postservice 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.

HC-FED104 01-19

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

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

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

Who is Entitled to COBRA Continuation?

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

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

Secondary Qualifying Events

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

Disability Extension

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

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

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

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

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

Medicare Extension for Your Dependents

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

Termination of COBRA Continuation

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

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

Moving Out of Employer's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer's service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

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

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your

Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

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

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

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

Grace periods for subsequent payments

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

You Must Give Notice of Certain Qualifying Events

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

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

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

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event.

COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's Bankruptcy

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

Conversion Available Following Continuation

If your or your Dependents' COBRA continuation ends due to the expiration of the maximum 18-, 29- or 36-month period, whichever applies, you and/or your Dependents may be entitled to convert to the coverage in accordance with the Medical Conversion benefit then available to Employees and the Dependents. Please refer to the section titled "Conversion Privilege" for more information.

Interaction With Other Continuation Benefits

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

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ERISA Required Information

The name of the Plan is:

ERISA Plan Name

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

ERISA Plan Sponsor Name
111 Street
City, FL 00000
000-000-0000

Employer Identification Number (EIN):	Plan Number:
00-0000000	501

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

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above

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

The Cigna Claim Office responsible for this Plan

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

The Plan's fiscal year ends on 12/31.

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

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

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

Discretionary Authority

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

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it.

Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

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

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

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

Statement of Rights

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this

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

HC-FED72 05-15

Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

HC-SPP4 04-10
V1

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.

HC-AAR1 01-17

When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted. We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

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

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free

number on your Benefit Identification card, explanation of benefits or claim form.

Florida Adverse Determination Medical Necessity Appeal

To initiate an Adverse Determination appeal, you must submit a request in writing to Cigna within 30 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 to write, you may ask Cigna to assist so that you may register your written appeal. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form. Your appeal will be reviewed and the decision made by individuals not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by an Internal Panel of health care professionals. For appeals involving Medical Necessity or clinical appropriateness, the Internal Panel will include at least one Physician in the same or similar specialty as the care under consideration, as determined by the Cigna Physician reviewer. For Adverse Determination Medical Necessity Appeals, we will acknowledge in writing that we have received your request and schedule a panel review. For preservice and concurrent care coverage determinations, the panel review will be completed within 30 calendar days and for post service claims, the panel review will be completed within 60 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Internal Panel to complete the review. You will be notified in writing of the Internal Panel's decision within five working days after the panel considers your request.

Expedited Medical Necessity Appeal

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 function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. The Cigna Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional. Please note that if you submit your written request within 30 days of receiving an initial denial notice, the Florida Adverse Determination Medical Necessity Appeal process described will apply. For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a 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. If an issue does not qualify for the Expedited Medical Necessity Appeal process, you may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal. Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may present your situation to the Committee in person or by conference call. For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage. If an issue does not qualify for the Expedited Medical Necessity Appeal process, 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 function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing

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

Appeal to the State of Florida

You have the right to contact the state regulators for assistance at any time. The state regulators may be contacted at the following addresses and telephone numbers:

The Statewide Provider and Subscriber Assistance Panel
Fort Knox Building One, Room 303
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456 or 850-921-5458
The Agency for Health Care Administration
Fort Knox Building One, Room 303
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456
The Department of Insurance
State Treasurer's Office
State Capitol, Plaza Level Eleven
Tallahassee, FL 32308
1-800-342-2762

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: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) 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; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and 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. You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

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

Legal Action

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

HC-APL380 01-20

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis as determined by your Employer on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1095 12-17

Ambulance

Licensed ambulance transportation services involve the use of specially designed and equipped vehicles for transporting ill or injured patients. It includes ground, air, or sea transportation when Medically Necessary and clinically appropriate.

HC-DFS1406 01-20

Ancillary Charge

An additional cost, outside of plan cost sharing detailed in The Schedule of Prescription Drug Benefits, which may apply to some Prescription Drug Products when you request a more expensive Brand Drug when a lower cost, Therapeutic Equivalent, Generic Drug is available. The Ancillary Charge is the amount by which the cost of the requested Brand Drug exceeds the cost of the Generic Drug.

HC-DFS1562 01-21

Biologic

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS840 10-16

Biosimilar

A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS841 10-16

Brand Drug

A Prescription Drug Product that Cigna identifies as a Brand Drug product 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.

HC-DFS842 10-16

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 effect changes regarding coverage treatment of Prescription Drug Products and Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, changes regarding tier placement and application of utilization management to Prescription Drug Products and Medical Pharmaceuticals.

HC-DFS1563 10-21

Charges

The term charges means 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.

HC-DFS1193 01-19

Convenience Care Clinic

Convenience Care Clinics are staffed by nurse practitioners and physician assistants and offer customers convenient, professional walk-in care for common ailments and routine services. Convenience Care Clinics have extended hours and are located in or near easy-to-access, popular locations (pharmacies, grocery and free-standing locations) with or without appointment.

HC-DFS1643 01-22

Custodial Services

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 service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

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

HC-DFS4 04-10
V1

Dependent – For Medical Insurance

Dependents are:

- your lawful spouse; and
- any child of yours:
  - who is less than 26 years old.
  - from 26 years until the end of the calendar year in which the child reaches the age of 30, provided the child is unmarried and does not have a dependent of his own, is a Florida state resident or a full-time or part-time student, and is not covered under a plan of his own or entitled to benefits under Title XVIII of the Social Security Act. Cigna may require such proof at least once each year until the end of the calendar year in which he attains age 30; and
  - who is 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence may be required to be submitted to the plan as a condition of coverage after the date the child ceases to qualify above. However, if a claim is denied, proof must be submitted by the Employee that the child is and has continued to be mentally or physically handicapped.

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. A child also includes a foster child or a child placed in your custody by a court order from the date of placement in the home. Coverage is not required if the adopted or foster child is ultimately not placed in your home. It also includes:

- a stepchild or a child for whom you are the legal guardian;
- a child born to an insured Dependent child of yours until such child is 18 months old.

Benefits for a Dependent child will continue until the last day of the calendar year in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent or Dependent spouse unless the Dependent or Dependent spouse declines Employee coverage.

A child under age 26 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee.

No one may be considered as a Dependent of more than one Employee.

HC-DFS1685 01-23

Designated Pharmacy

A Network Pharmacy that has entered into an agreement with Cigna, or with an entity contracting on Cigna's behalf, to provide Prescription Drug Products or services, including, without limitation, specific Prescription Drug Products, to plan enrollees on a preferred or exclusive basis. For example, a Designated Pharmacy may provide enrollees certain Specialty Prescription Drug Products that have limited distribution availability, provide enrollees with an extended days' supply of Prescription Drug Products or provide enrollees with Prescription Drug Products on a preferred cost share basis. A Pharmacy that is a Network Pharmacy is not necessarily a Designated Pharmacy.

HC-DFS1564 01-21

Emergency Medical Condition

Emergency Medical Condition means 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.

HC-DFS1765 01-23

Emergency Services

Emergency Services means, 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.

HC-DFS1763 01-23

Employee

The term Employee means an Employee as determined by your Employer who is currently in Active Service.

HC-DFS1094 12-17

Employer

The term Employer means the policyholder and those affiliated Employers whose Employees are covered under this Policy.

HC-DFS1566 01-21

Essential Health Benefits

Essential health benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

HC-DFS411 01-11

Expense Incurred

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

HC-DFS10 04-10
V1

Free-Standing Surgical Facility

The term Free-Standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

A Free-Standing Surgical Facility, unless specifically noted otherwise, is covered with the same cost share as an Outpatient Facility.

HC-DFS1407 01-20

Generic Drug

A Prescription Drug Product that Cigna identifies as a Generic Drug product 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 products 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.

HC-DFS846 10-16

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

HC-DFS51 04-10
V1

Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

HC-DFS52 04-10
V1

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

HC-DFS53 04-10
V1

Hospital

The term Hospital means:

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

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

HC-DFS1429 01-20

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

HC-DFS807 12-15

Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

Maintenance Drug Product

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 member services at the telephone number on your ID card.

HC-DFS847 10-16

Maintenance Treatment

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

HC-DFS56 04-10
V1

Maximum Reimbursable Charge - Medical

The Maximum Reimbursable Charge for covered services for Open Access Plus 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
- a policyholder-selected 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 state, regional or national charge data may be used. 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 percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS1642 01-22
V2

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.

HC-DFS16 04-10
V1

Medical Pharmaceutical

Medical Pharmaceuticals are used for treatment of complex chronic conditions, are administered and handled in a specialized manner, and may be high cost. Because of their characteristics, they require a qualified Physician to administer or directly supervise administration. Some Medical Pharmaceuticals may initially or typically require Physician oversight but subsequently may be self-administered under certain conditions specified in the product's FDA labeling.

HC-DFS1751 01-24

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:

- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;

- not primarily for the convenience of the patient, Physician or Other Health Professional;
- 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
- 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.

In determining whether health care services, supplies, or medications are Medically Necessary, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

HC-DFS1411 01-20

Medicare

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

HC-DFS17 04-10
V1

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Room and Board, made by a Hospital for medical services and supplies actually used during Hospital Confinement.

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

HC-DFS1409 01-20

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.
- been designated as a Network Pharmacy for the purposes of coverage under your Employer’s plan.

This term may also include, as applicable, an entity that has directly or indirectly contracted with Cigna to arrange for the provision of any Prescription Drug Products the charges for which are Covered Expenses.

HC-DFS1198 01-19

New Prescription Drug Product

A Prescription Drug Product, or new use or dosage form of a previously FDA-approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or newly-approved use or dosage form becomes available on the market following approval by the U.S. Food and Drug Administration (FDA) and ending on the date Cigna makes a Prescription Drug List coverage status decision.

HC-DFS1568 01-21

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

HC-DFS22 04-10
V1

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

HC-DFS1412 01-20

Other Health Professional

The term Other Health Professional means 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 Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS1413 01-20

Participating Provider

The term Participating Provider means a person or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies, the Charges for which are Covered Expenses. It includes 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, the Charges for which are Covered Expenses.

HC-DFS1194 01-19

Patient Protection and Affordable Care Act of 2010 ("PPACA")

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

HC-DFS412 01-11

Pharmacy

A duly licensed Pharmacy that dispenses Prescription Drug Products in a retail setting or via home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drug Products through mail order.

HC-DFS851 10-16

Pharmacy & Therapeutics (P&T) Committee

A committee comprised of Physicians and an independent pharmacist that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals or Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage determinations made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

HC-DFS1570 01-21

Physician

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

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

HC-DFS25 04-10
V1

Prescription Drug Charge

The Prescription Drug Charge is the amount that, prior to application of the plan's cost-share requirement(s), is payable by Cigna to its Pharmacy Benefit Manager for a specific covered Prescription Drug Product dispensed at a Network Pharmacy, including any applicable dispensing fee and tax. The "Pharmacy Benefit Manager" is the business unit, affiliate, or other entity that manages the Prescription Drug Benefit for Cigna.

HC-DFS1191 01-19

Prescription Drug List

A list that categorizes Prescription Drug Products covered under the plan's Prescription Drug Benefits into coverage tiers. This list is developed by Cigna based on clinical factors communicated by the P&T Committee and adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned

through the website shown on your ID card or by calling customer service at the telephone number on your ID card.

HC-DFS1752 01-24

Prescription Drug Product

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. For the purpose of benefits under the plan, this definition may also include products in the following categories if specifically identified on the Prescription Drug List:

- Certain durable products and supplies that support drug therapy;
- Certain diagnostic testing and screening services that support drug therapy;
- Certain medication consultation and other medication administration services that support drug therapy;
- Certain digital products, applications, electronic devices, software and cloud-based service solutions used to predict, detect and monitor health conditions in support of drug therapy.

HC-DFS1645 01-22

Prescription Order or Refill

The lawful directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

HC-DFS856 10-16

Preventive Care Medications

The Prescription Drug Products 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:

- 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.
- 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.
- 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.

HC-DFS857 10-16

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

HC-DFS57 04-10
V1

Primary Care Physician

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice OB/GYN or pediatrics; and who has been voluntarily selected by you and is contracted as a Primary Care Physician with, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

HC-DFS40 04-10
V1

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

HC-DFS26 04-10
V1

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 members who perform utilization review services.

HC-DFS808 12-15

Room and Board

The term Room and Board includes all charges made by a Hospital for room and meals and for all general services and activities needed for the care of registered bed patients.

HC-DFS1408 01-20

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

HC-DFS50 04-10
V1

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

HC-DFS31 04-10
V1

Specialist

The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

HC-DFS33 04-10
V1

Specialty Prescription Drug Product

A Prescription Drug Product or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Prescription Drug Product or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug Product or Medical Pharmaceutical has a high acquisition cost; and, whether the Prescription Drug Product 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 Product 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 Product or Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products 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 Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-DFS858 10-16

Spinal Manipulation Care

The term Spinal Manipulation Care means 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.

HC-DFS1684 01-23

Stabilize

Stabilize means, 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.

HC-DFS1767 01-23

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

HC-DFS54 04-10
V1

Therapeutic Alternative

A Prescription Drug Product or Medical Pharmaceutical that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

HC-DFS859 10-16

Therapeutic Equivalent

A Prescription Drug Product or Medical Pharmaceutical that is a pharmaceutical equivalent to another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

HC-DFS860 10-16

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which 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. Such care includes, but is 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.

HC-DFS34 04-10
V1

Usual and Customary (U&C) Charge

The usual fee that a Pharmacy charges individuals for a Prescription Drug Product (and any services related to the dispensing thereof) without reference to reimbursement to the Pharmacy by third parties. The Usual and Customary (U&C) Charge includes a dispensing fee and any applicable sales tax.

HC-DFS861 10-16

Sample Florida OAPIN Certificate

OPEN ACCESS PLUS IN-NETWORK
MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2025

SAMPLE

This document printed in June, 2024 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Sample Florida OAPIN Certificate

GROUP POLICY(S) — COVERAGE

0000000 - OAPIN OPEN ACCESS PLUS IN-NETWORK MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2025

THE BENEFITS IN THIS CERTIFICATE CONTAIN A DEDUCTIBLE PROVISION

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

Geneva Cambell Brown, Corporate Secretary

HC-CER5 04-10
V1

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

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

Special Plan Provisions

Participating Providers include Physicians, Hospitals and Other Health 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.

Services Available in Conjunction With Your Medical Plan

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.

HC-SPP63 01-20

Case Management

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, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) 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.

HC-SPP2 04-10
V1

Additional Programs

We 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 members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

HC-SPP3 04-10
V1

Incentives to Participating Providers

Cigna continuously develops programs to help our customers access quality, cost-effective health care. Some programs include Participating Providers receiving financial incentives from Cigna for providing care to Members in a way that meets or exceeds certain quality and/or cost-efficiency standards, when, in the Participating Provider's professional judgment, it is appropriate to do so within the applicable standard of care. For example, some Participating Providers could receive financial incentives for utilizing or referring you to alternative sites of care as determined by your plan rather than in a more expensive setting, or achieving particular outcomes for certain health conditions. Participating Providers may also receive purchasing discounts when purchasing certain prescription drugs from Cigna affiliates. Such programs can help make you healthier, decrease your health care costs, or both. These programs are not intended to affect your access to the health care that you need. We encourage you to talk to your Participating Provider if you have questions about whether they receive financial incentives from Cigna and whether those incentives apply to your care.

HC-SPP81 01-24

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.

HC-SPP27 06-15
V1

Important Notices

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 Drug Products included on the Prescription Drug List. These rebates or remuneration are not obtained on you or your Employer's or plan'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 may also conduct business with various pharmaceutical manufacturers separate and apart from this plan's Medical Pharmaceutical and Prescription Drug Product 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 Drug Products. 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 Product 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 Product 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 Product, 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 Product, 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.

HC-IMP260 01-20
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Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service 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 number on the back of 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 or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

HC-NOT96 07-17

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки

участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY : اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese –
注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711را شمارەگیری کنید).

HC-NOT97 07-17

Federal CAA - Consolidated Appropriations Act and TIC - Transparency in Coverage Notice

Cigna will make available an internet-based self-service tool for use by individual customers, as well as certain data in machine-readable file format on a public website, as required under the Transparency in Coverage rule. Customers can access the cost estimator tool on myCigna.com. Updated machine-readable files can be found on Cigna.com and/or CignaForEmployers.com on a monthly basis.

Pursuant to Consolidated Appropriations Act (CAA), Section 106, Cigna will submit certain air ambulance claim information to the Department of Health and Human Services (HHS) in accordance with guidance issued by HHS.

Subject to change based on government guidance for CAA Section 204, Cigna will submit certain prescription drug and health care spending information to HHS through Plan Lists Files (P1-P3) and Data Files (D1-D8) (D1-D2) for an Employer without an integrated pharmacy product aggregated at the market segment and state level, as outlined in guidance.

HC-IMP324 01-23

Federal CAA - Consolidated Appropriations Act

Continuity of Care

In certain circumstances, if you are receiving continued care from an in-network provider or facility, and that provider's network status changes from in-network to out-of-network, you may be eligible to continue to receive care from the provider at the in-network cost-sharing amount for up to 90 days from the date you are notified of your provider's termination. A continuing care patient is an individual who is:

- Undergoing treatment for a serious and complex condition
- Pregnant and undergoing treatment for the pregnancy
- Receiving inpatient care
- Scheduled to undergo urgent or emergent surgery, including postoperative
- Terminally ill (having a life expectancy of 6 months or less) and receiving treatment from the provider for the illness

If applicable, Cigna will notify you of your continuity of care options.

Appeals

Any external review process available under the plan will apply to any adverse determination regarding claims subject to the No Surprises Act.

Provider Directories and Provider Networks

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

A list of network pharmacies is available to you, without charge, by visiting the website or 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.

Provider directory content is verified and updated, and processes are established for responding to provider network status inquiries, in accordance with applicable requirements of the No Surprises Act.

If you rely on a provider's in-network status in the provider directory or by contacting Cigna at the website or phone number on your ID card to receive covered services from that provider, and that network status is incorrect, then your plan cannot impose out-of-network cost shares to that covered service. In-network cost share must be applied as if the covered service were provided by an in-network provider.

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan 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, access the website or call the phone number on 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, access the website or call the phone number on your ID card.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these situations, you should not be charged more than your plan's copayments, coinsurance, and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**". This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care – such as when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

- **Emergency services** – If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as a copayments, coinsurance, and deductibles). You cannot be balanced billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Certain non-emergency services at an in-network hospital or ambulatory surgical center –** When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balanced billed.

If you get other types of services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you have these protections:

- You are only responsible for paying your share of the cost (such as copayments, coinsurance, and deductibles that you would pay if the provider were in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval in advance for services (also known as prior authorization).
  - Cover emergency services provided by out-of-network providers.
  - Base what you owe the provider or facility (cost sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits (EOB).
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you have been wrongly billed, contact Cigna at the phone number on your ID card. You can also contact No Surprises Help Desk at 1-800-985-3059 or http://www.cms.gov/nosurprises for more information about your rights under federal law.

HC-IMP325 01-23

How To File Your Claim

If your plan provides coverage when care is received only from In-Network providers, 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 calling 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 BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT 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.

If it was not reasonably possible to give proof in the time required, Cigna will not reduce or deny the claim for this reason if the proof is submitted as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified unless the claimant was legally incapacitated.

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

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V2

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees as determined by your Employer; and

- you are an eligible Employee as determined by your Employer; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Eligibility for Dependent Insurance

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

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

Waiting Period

Initial Employee Group: As determined by your Employer.

New Employee Group: As determined by your Employer.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included. For your Dependents to be insured for these benefits, you must elect the Dependent insurance for yourself no later than 30 days after you become eligible.

A newborn child will be covered for the first 31 days of life even if you fail to enroll the child. If you enroll the child after the first 31 days and by the 60th day after his birth, coverage will be offered at an additional premium. Coverage for an adopted child will become effective from the date of placement in your home or from birth for the first 31 days even if you fail to enroll the child. However, if you enroll the adopted child between the 31st and 60th days after his birth or placement in your home, coverage will be offered at an additional premium.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

If notice is given within 60 days of the birth of the child, the insurer may not deny coverage for a child due to the failure of the insured to timely notify the insurer of the birth of the child.

HC-ELG326 03-21

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care

Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents. If you need assistance selecting your Primary Care Physician, please visit our website at www.cigna.com or call the number on the back of your ID Card.

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

You and your Dependents are allowed direct access to Participating Physicians for covered services. Even if you select a Primary Care Physician, there is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Physician of your choice, including Participating Specialist Physicians, for covered services.

Changing Primary Care Physicians

You may request a transfer from one Primary Care Physician to another by visiting our website at www.cigna.com or calling the number on the back of your ID Card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

Direct Access For Mental Health and Substance Use Disorder Services

You are allowed direct access to a licensed/certified Participating Provider for covered Mental Health and Substance Use Disorder Services. There is no requirement to obtain an authorization of care from your Primary Care Physician for individual or group therapy visits to the Participating Provider of your choice for Mental Health and Substance Use Disorder.

Open Access Plus In-Network Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus In-Network Medical Benefits provide coverage for care In-Network. To receive Open Access Plus In-Network Medical Benefits, you and your Dependents 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 Covered Expenses that an insured person is required to pay under the plan in addition to the Deductible, if any.

Copayments/Deductibles

Copayments are amounts to be paid by you or your Dependent for covered services. Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this plan. 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.

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 Deductibles, 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%.

Multiple Surgical Reduction

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

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

Open Access Plus In-Network Medical Benefits

The Schedule

Out-of-Network Charges for Certain Services (Non-Emergency)

Charges for services furnished by an Out-of-Network provider in an In-Network facility while you are receiving In-Network services at that In-Network facility: (i) are payable at the In-Network cost-sharing level; and (ii) the allowable amount used to determine the Plan's benefit payment is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.

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.

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, other facility as required by Florida law, 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. If the provider and Cigna cannot agree on an allowable amount, Cigna or the provider may request dispute resolution pursuant to Florida law. Out-of-Network providers who are subject to Florida law may not attempt to collect from you any amount in excess of the allowable amount.

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.

Out-of-Network Air Ambulance Services Charges

1. Covered air ambulance services are payable 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 air ambulance services rendered by an Out-of-Network provider is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.

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.

BENEFIT HIGHLIGHTS	IN-NETWORK
Lifetime Maximum	Unlimited
The Percentage of Covered Expenses the Plan Pays	90%
Calendar Year Deductible	
Individual	$500 per person
Family Maximum	$1,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.	
Combined Medical/Pharmacy Calendar Year Deductible	
Combined Medical/Pharmacy Deductible: includes retail and home delivery drugs	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Deductible	No
Out-of-Pocket Maximum	
Individual	$1,000 per person
Family Maximum	$2,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.	

BENEFIT HIGHLIGHTS	IN-NETWORK
Physician's Services	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
Consultant and Referral Physician's Services	
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna on an In-Network basis.	
Surgery Performed in the Physician's Office	
Primary Care Physician	Plan deductible, then 90%
Specialty Care Physician	Plan deductible, then 90%
Second Opinion Consultations (provided on a voluntary basis)	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
Allergy Treatment/Injections	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
Allergy Serum (dispensed by the Physician in the office)	
Primary Care Physician	Plan deductible, then 90%
Specialty Care Physician	Plan deductible, then 90%
Convenience Care Clinic (includes any related lab and x-ray services and surgery)	Plan deductible, then 90%

BENEFIT HIGHLIGHTS	IN-NETWORK
Virtual Care	
Dedicated Virtual Providers Dedicated virtual care services may be provided by MDLIVE, a Cigna affiliate. Services available through contracted virtual providers as medically appropriate. **Notes:** • Primary Care cost share applies to routine care. Virtual wellness screenings are payable under preventive care. • MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below). • Lab services supporting a virtual visit must be obtained through dedicated labs.	
MDLIVE Urgent Care Services	Plan deductible, then 90%
MDLIVE Primary Care Services	Plan deductible, then 90%
MDLIVE Specialty Care Services	Plan deductible, then 90%
Virtual Physician Services Services available through Physicians as medically appropriate. **Note:** Preventive services covered at the preventive level.	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician’s Office Visit	Plan deductible, then 90%
Preventive Care	
Routine Preventive Care - all ages	100%
Immunizations - all ages	100%

BENEFIT HIGHLIGHTS	IN-NETWORK
Mammograms, PSA, PAP Smear	
Preventive Care Related Services (i.e. "routine" services)	100%
Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray benefit & lab benefit; based on place of service
Women's Surgical Sterilization Procedures (e.g. tubal ligation) Excludes reversals	
Primary Care Physician's Office Visit	100%
Specialty Care Physician's Office Visit	100%
Inpatient Facility	100%
Outpatient Facility	100%
Inpatient Professional Services	100%
Outpatient Professional Services	100%
Inpatient Hospital - Facility Services	Plan deductible, then 90%
Semi-Private Room and Board	Limited to the semi-private negotiated rate
Private Room	Limited to the semi-private negotiated rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate
Outpatient Facility Services	
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	Plan deductible, then 90%
Inpatient Hospital Physician's Visits/Consultations	Plan deductible, then 90%
Inpatient Professional Services	Plan deductible, then 90%
Surgeon	
Radiologist, Pathologist, Anesthesiologist	
Outpatient Professional Services	Plan deductible, then 90%
Surgeon	
Radiologist, Pathologist, Anesthesiologist	

BENEFIT HIGHLIGHTS	IN-NETWORK
Urgent Care Services	
Urgent Care Facility or Outpatient Facility Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the UC visit.	$50 per visit copay, then plan deductible, then 90%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the UC visit	$50 per visit copay, then plan deductible, then 90%
Emergency Services	
Hospital Emergency Room Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.	$100 per visit copay (waived if admitted), then plan deductible, then 90%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER visit	$100 per visit copay (waived if admitted), then plan deductible, then 90%
Air Ambulance	Plan deductible, then 90%
Ambulance	Plan deductible, then 90%
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: Unlimited	Plan deductible, then 90%
Laboratory Services	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
Outpatient Hospital Facility	Plan deductible, then 90%
Independent Lab Facility	Plan deductible, then 90%

BENEFIT HIGHLIGHTS	IN-NETWORK
Radiology Services	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
Outpatient Hospital Facility	Plan deductible, then 90%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
Inpatient Facility	Plan deductible, then 90%
Outpatient Facility	Plan deductible, then 90%
Outpatient Therapy Services and Spinal Manipulation Services Calendar Year Maximum: Unlimited Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Spinal Manipulation Services (includes Chiropractors)	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
Home Health Care Services	
Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)	Plan deductible, then 90%

BENEFIT HIGHLIGHTS	IN-NETWORK
Hospice	
Inpatient Services	Plan deductible, then 90%
Outpatient Services (same coinsurance level as Home Health Care Services)	Plan deductible, then 90%
Bereavement Counseling	
Services provided as part of Hospice Care	
Inpatient	Plan deductible, then 90%
Outpatient	Plan deductible, then 90%
Services provided by Mental Health Professional	Covered under Mental Health benefit
Medical Pharmaceuticals	
Inpatient Facility	Plan deductible, then 90%
Cigna Pathwell Specialty Medical Pharmaceuticals	Cigna Pathwell Specialty Network provider: 100% Non-Cigna Pathwell Specialty Network Providers: Not Covered
Other Medical Pharmaceuticals	Plan deductible, then 90%
Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary. Gene therapy must be received at an In-Network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other In-Network facilities is not covered.	
Gene Therapy Product	Covered same as Medical Pharmaceuticals
Inpatient Hospital Facility Services	Plan deductible, then 90%
Outpatient Facility	Plan deductible, then 90%
Inpatient Professional Services	Plan deductible, then 90%
Outpatient Professional Services	Plan deductible, then 90%
Travel Maximum: $10,000 per episode of gene therapy	100% (available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy)

BENEFIT HIGHLIGHTS	IN-NETWORK
Advanced Cellular Therapy Includes prior authorized advanced cellular therapy products and related services when Medically Necessary.	
Advanced Cellular Therapy Product	Covered Same as Medical Pharmaceuticals
Inpatient Facility	Plan deductible, then 90%
Outpatient Facility	Plan deductible, then 90%
Inpatient Professional Services	Plan deductible, then 90%
Outpatient Professional Services	Plan deductible, then 90%
Advanced Cellular Therapy Travel Maximum: $10,000 per episode of advanced cellular therapy (Available only for travel when prior authorized to receive advanced cellular therapy from a provider located more than 60 miles of your primary residence and is contracted with Cigna for the specific advanced cellular therapy product and related services.)	100%

BENEFIT HIGHLIGHTS	IN-NETWORK
Maternity Care Services	
Initial Visit to Confirm Pregnancy **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna on an In-Network basis.	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Plan deductible, then 90%
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
Delivery - Facility (Inpatient Hospital, Birthing Center)	Plan deductible, then 90%
Abortion Includes elective and non-elective procedures	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
Inpatient Facility	Plan deductible, then 90%
Outpatient Facility	Plan deductible, then 90%
Inpatient Professional Services	Plan deductible, then 90%
Outpatient Professional Services	Plan deductible, then 90%

BENEFIT HIGHLIGHTS	IN-NETWORK
Infertility Treatment Services Not Covered include: • 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 means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not Covered
Transplant Services and Related Specialty Care Includes all medically appropriate, non-experimental transplants	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
Inpatient Facility	100% at Lifesource center, otherwise plan deductible, then 90%
Inpatient Professional Services	100% at Lifesource center, otherwise plan deductible, then 90%
Lifetime Travel Maximum: $10,000 per transplant	100% (only available when using Lifesource facility)
Durable Medical Equipment Calendar Year Maximum: Unlimited	Plan deductible, then 90%
Outpatient Dialysis Services	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
Outpatient Facility Services	Plan deductible, then 90%
Home Setting	Plan deductible, then 90%

BENEFIT HIGHLIGHTS	IN-NETWORK
External Prosthetic Appliances Calendar Year Maximum: Unlimited	Plan deductible, then 90%
Diabetic Equipment Calendar Year Maximum: Unlimited	Plan deductible, then 90%
Nutritional Counseling Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of diabetes and/or to mental health and substance use disorder conditions.	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
Inpatient Facility	Plan deductible, then 90%
Outpatient Facility	Plan deductible, then 90%
Inpatient Professional Services	Plan deductible, then 90%
Outpatient Professional Services	Plan deductible, then 90%
Genetic Counseling Calendar Year Maximum: 3 visits per person for Genetic Counseling for both pre- and post-genetic testing; however, the 3 visit limit will not apply to Mental Health and Substance Use Disorder conditions.	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
Inpatient Facility	Plan deductible, then 90%
Outpatient Facility	Plan deductible, then 90%
Inpatient Professional Services	Plan deductible, then 90%
Outpatient Professional Services	Plan deductible, then 90%

BENEFIT HIGHLIGHTS	IN-NETWORK
Dental Care Limited to charges made for a continuous course of dental treatment for an Injury to teeth.	
Primary Care Physician's Office Visit	Plan deductible, then 90%
Specialty Care Physician's Office Visit	Plan deductible, then 90%
Inpatient Facility	Plan deductible, then 90%
Outpatient Facility	Plan deductible, then 90%
Inpatient Professional Services	Plan deductible, then 90%
Outpatient Professional Services	Plan deductible, then 90%
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.	

BENEFIT HIGHLIGHTS	IN-NETWORK
Mental Health	
Inpatient Includes Acute Inpatient and Residential Treatment Calendar Year Maximum: Unlimited	Plan deductible, then 90%
Outpatient	
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 90%
Dedicated Virtual Providers MDLIVE Behavioral Services	Plan deductible, then 90%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 90%

BENEFIT HIGHLIGHTS	IN-NETWORK
Substance Use Disorder	
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Calendar Year Maximum: Unlimited	Plan deductible, then 90%
Outpatient	
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 90%
Dedicated Virtual Providers MDLIVE Behavioral Services	Plan deductible, then 90%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 90%

Open Access Plus In-Network Medical Benefits

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays.
- inpatient services at any participating Other Health Care Facility.
- residential treatment.
- outpatient facility services.
- partial hospitalization.
- advanced radiological imaging.
- non-emergency Ambulance.
- certain Medical Pharmaceuticals.
- home health care services.
- radiation therapy.
- transplant services.

Covered Expenses

The term Covered Expenses means 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.

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.

Any applicable Copayments, Deductibles or limits are shown in The Schedule.

Covered Expenses

- charges for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital, subject to the limits as shown in The Schedule.
- charges for inpatient Room and Board and other Necessary Services and Supplies made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility as shown in The Schedule.
- charges for licensed ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
- charges for outpatient medical care and treatment received at a Hospital.
- charges for outpatient medical care and treatment received at a Free-Standing Surgical Facility.
- charges for Emergency Services.
- charges for Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse for professional nursing service.
- charges made for anesthetics, including, but not limited to supplies and their administration.
- charges for diagnostic x-ray.
- charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.
- charges for chemotherapy.
- charges for blood transfusions.
- charges for oxygen and other gases and their administration.
- charges made for Medically Necessary foot care for diabetes, peripheral neuropathies, and peripheral vascular disease.
- charges made for screening prostate-specific antigen (PSA) testing.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges for men’s family planning, counseling, testing and sterilization (e.g. vasectomies), excluding reversals.
- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: a baseline mammogram for women ages

35 through 39; a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; a mammogram every year for women age 50 and over; and one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician's recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.

- charges made for preventive care services as defined by recommendations from the following:
  - the U.S. Preventive Services Task Force (A and B recommendations);
  - the Advisory Committee on Immunization Practices (ACIP) for immunizations;
  - the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;
  - the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
  - with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.

  Detailed information is available at www.healthcare.gov. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.
- charges made for diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint. Appliances and non-surgical treatment including for orthodontia are not covered.
- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.
- charges for general anesthesia and hospitalization services for dental procedures for an individual who is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.
- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.
- charges made for 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. Services provided to you by a certified nurse-midwife or a licensed midwife, in a home setting or in a licensed birthing center. Coverage for a mother and her newborn child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. Post delivery care for a mother and her newborn shall be covered. Post delivery care includes: a postpartum assessment and newborn assessment, which can be provided at the hospital, the attending Physician's office, and outpatient maternity center or in the home by an Other Health Care Professional trained in mother and newborn care. The services may include physical assessment of the newborn and mother, and the performance of any clinical tests and immunizations in keeping with prevailing medical standards.
- charges for coverage for diagnosis and treatment of autism spectrum disorder to include autistic disorder, Asperger's Syndrome and pervasive developmental disorder not otherwise specified, when prescribed by a treating Physician. Treatment includes well-baby and well-child screening for diagnosis and treatment through speech therapy, occupational therapy, physical therapy and applied behavior analysis.
- charges for the treatment of Down syndrome through speech therapy, occupational therapy, physical therapy and applied behavioral analysis. Includes habilitative and rehabilitative services.
- charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: have vertebral abnormalities; are receiving long-term glucocorticoid (steroid) therapy; have primary hyperparathyroidism; have a family history of osteoporosis; and/or are estrogen-deficient individuals who are at clinical risk for osteoporosis.
- charges for or in connection with a bone marrow transplant when recommended by a Physician and deemed acceptable by the appropriate oncological specialty. This treatment cannot be considered experimental under the rules of the Secretary of Health and Rehabilitative Services. Please call your Claims Office prior to receiving any treatment in order to determine your benefits.
- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be Medically Necessary by the Physician and in consultation

with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.

- charges for newborn and infant hearing screening as well as any medically necessary follow-up evaluations leading to diagnosis and subsequent medically necessary treatment of a diagnosed hearing impairment.
- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.
- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage on oral contraceptives.
- charges for the coverage of child health supervision services from birth to age 16. Child health supervision services are physician-delivered or supervised services that include periodic visits which include a history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests.

Convenience Care Clinic

Convenience Care Clinics provide for common ailments and routine services, including but not limited to, strep throat, ear infections or pink eye, immunizations and flu shots.

Virtual Care: Medical

Dedicated Virtual Providers

Includes charges for the delivery of real-time medical and health-related services, consultations, and remote monitoring by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.

Includes charges for the delivery of mental health and substance use disorder-related services, consultations, and remote monitoring by dedicated virtual providers as appropriate through audio, video and secure internet-based technologies.

Virtual Physician Services

Includes charges for the delivery of real-time medical and health-related services, consultations, and remote monitoring as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.

Includes charges for the delivery of real-time mental health and substance use disorder consultations and services, via secure telecommunications technologies that shall include video capability, telephone and internet, when such consultations and services are delivered by a behavioral provider and are similar to office visit services provided in a face-to-face setting.

Nutritional Counseling

Charges for counseling when diet is a part of the medical management of a medical or behavioral condition.

Enteral Nutrition

Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism (e.g., disorders of amino acid or organic acid metabolism).

Internal Prosthetic/Medical Appliances

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

HC-COV1345 01-24

Home Health Care Services

Charges for skilled care provided by certain health care providers during a visit to the home, when the home is determined to be a medically appropriate setting for the services. A visit is defined as a period of 2 hours or less. Home Health Care Services are subject to a maximum of 16 hours in total per day.

Home Health Care Services are covered when skilled care is required under any of the following conditions:

- the required skilled care cannot be obtained in an outpatient facility.
- confinement in a Hospital or Other Health Care Facility is not required.
- the patient’s home is determined by Cigna to be the most medically appropriate place to receive specific services.

Covered services include:

- skilled nursing services provided by a Registered Nurse (RN); Licensed Practical Nurse (LPN); Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse (APRN).
- services provided by health care providers such as a physical therapist; occupational therapist or speech therapist.
- services of a home health aide when provided in direct support of those Nurses and health care providers.
- necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.

Note: Physical, occupational, and other Outpatient Therapy Services provided in the home are covered under the Outpatient Therapy Services benefit shown in The Schedule.

The following are excluded from coverage:

- services provided by a person who is a member of the patient's family, even when that person is a health care provider.
- services provided by a person who normally resides in the patient's house, even when that person is a health care provider.
- non-skilled care, Custodial Services, and assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other services; self-care activities; homemaker services; and services primarily for rest, domiciliary or convalescent care.

Home Health Care Services, for a patient who is dependent upon others for non-skilled care and/or Custodial Services, is provided only when there is a family member or caregiver present in the home at the time of the health care visit to provide the non-skilled care and/or Custodial Services.

HC-COV1007 01-21

Hospice Care Services

Charges for services for a person diagnosed with advanced Illness (having a life expectancy of twelve or fewer months). Services provided by a Hospice Care Program are available to those who have ceased treatment and to those continuing to receive curative treatment and therapies.

A Hospice Care Program rendered by a Hospice Facility or Hospital includes services:

- by a Hospice Facility for Room and Board and Services and Supplies;
- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies.

A Hospice Care Program rendered by an Other Health Care Facility or in the Home includes services:

- part-time or intermittent nursing care by or under the supervision of a Nurse;
- part-time or intermittent services of an Other Health Professional;
- physical, occupational and speech therapy;
- medical supplies;
- drugs and medicines lawfully dispensed only on the written prescription of a Physician;
- 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:

- 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;
- services for any period when you or your Dependent is not under the care of a Physician;
- services or supplies not listed in the Hospice Care Program;
- to the extent that any other benefits are payable for those expenses under the policy;
- services or supplies that are primarily to aid you or your Dependent in daily living.

HC-COV1185 01-22

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 of 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

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include 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 you or your Dependent 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 you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance 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 you or your Dependent 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.

Exclusions

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

- 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.

HC-COV481V6 12-15

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person'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 Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, ventilators, insulin pumps and wheel chairs.

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

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers and air purifiers.
- **Other Equipment:** centrifuges, needleless injectors, heat lamps, heating pads, cryounits, cryotherapy machines, ultraviolet cabinets that emit Ultraviolet A (UVA) rays, sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment and diathermy machines.

HC-COV1008 01-21

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect.

External prosthetic appliances and devices 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:

- limb prostheses;
- terminal devices such as hands or hooks;
- speech prostheses; and
- facial 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:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;

- when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
- for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- non-foot orthoses primarily used for cosmetic rather than functional reasons; and
- non-foot 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 required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- replacement due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited as follows:

- no more than once every 24 months for persons 19 years of age and older.
- no more than once every 12 months for persons 18 years of age and under.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements for external prosthetic devices;
- microprocessor controlled prostheses and orthoses; and
- myoelectric prostheses and orthoses.

HC-COV1009 01-21

Outpatient Therapy Services

Charges for the following therapy services when provided as part of a program of treatment: **Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy**

Cardiac Rehabilitation

- Charges for Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

  Phase III and Phase IV cardiac rehabilitation are not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

Spinal Manipulation Services

- Charges for diagnostic and treatment services utilized in an office setting by spinal manipulation Physicians. Spinal manipulation 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. For these services you have direct access to qualified spinal manipulation Physicians.

Coverage is provided when Medically Necessary in the most medically appropriate setting to:

- Restore function (called rehabilitative):
  - To restore function that has been impaired or lost.
  - To reduce pain as a result of Sickness, Injury, or loss of a body part.

- Improve, adapt or attain function (sometimes called habilitative):
  - To improve, adapt or attain function that has been impaired or was never achieved as a result of congenital abnormality (birth defect).
  - To improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions. Includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.

Coverage is provided as part of a program of treatment when the following criteria are met:

- The individual's condition has the potential to improve or is improving in response to therapy, and maximum improvement is yet to be attained.
- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The therapy is provided by, or under the direct supervision of, a licensed health care professional acting within the scope of the license.
- The therapy is Medically Necessary and medically appropriate for the diagnosed condition.

Coverage for occupational therapy is provided only for purposes of enabling individuals to perform the activities of daily living after an Injury or Sickness.

Therapy services that are not covered include:

- sensory integration therapy,
- treatment of dyslexia,
- maintenance or preventive treatment provided to prevent recurrence or to maintain the patient's current status,
- charges for Spinal Manipulation Care not provided in an office setting,
- vitamin therapy.

Coverage is administered according to the following:

- Multiple therapy services provided on the same day constitute one day of service for each therapy type.

HC-COV1101 03-21

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and prosthetics, limited to the lowest cost alternative available that meets prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is 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. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

HC-COV631 12-17

Transplant Services and Related Specialty Care

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. Implantation procedures for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO), ventricular assist device (VAD), and intra-aortic balloon pump (IABP) are also covered.

- All transplant services and related specialty care services, other than cornea transplants, are covered when received at Cigna LifeSOURCE Transplant Network® facilities.
- Transplant services and related specialty care services received at Participating Provider facilities specifically contracted with Cigna for those transplant services and related specialty care services, other than Cigna

LifeSOURCE Transplant Network® facilities, are payable at the In-Network level.

- Transplant services and related specialty care services received at any other facility, including non-Participating Provider facilities and Participating Provider facilities not specifically contracted with Cigna for transplant services and related specialty care services, are not covered.
- Cornea transplants received at a facility that is specifically contracted with Cigna for this type of transplant are payable at the In-Network level.

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 hospitalization and surgery necessary for removal of an organ and transportation of a live donor (refer to Transplant and Related Specialty Care Travel Services). 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 and Related Specialty Care Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations:

- Transplant and related specialty care travel benefits are not available for cornea transplants.
- Benefits for transportation and lodging are available to the recipient of a pre-approved organ/tissue transplant and/or related specialty care 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 designated Cigna LifeSOURCE Transplant Network® facility (including charges for a rental car used during a period of care at the Cigna designated LifeSOURCE Transplant Network® facility); and lodging while at, or traveling to and from the Cigna LifeSOURCE Transplant Network® facility.
- In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver 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 for Transplant Services and Related Specialty Care, and for Transplant and Related Specialty Care Travel Services are only available when the covered person 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 transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant; the transplant recipient's plan would cover all donor costs.

HC-COV1325 01-24

Advanced Cellular Therapy

Charges for advanced cellular therapy products and services directly related to their administration are covered when Medically Necessary. Coverage includes the cost of the advanced cellular therapy product; medical, surgical, and facility services directly related to administration of the advanced cellular therapy product, and professional services.

Cigna determines which U.S. Food and Drug Administration (FDA) approved products are in the category of advanced cellular therapy, based on the nature of the treatment and how it is manufactured, distributed and administered. An example of advanced cellular therapy is chimeric antigen receptor (CAR) T-cell therapy that redirects a person's T cells to recognize and kill a specific type of cancer cell.

Advanced cellular therapy products and their administration are covered at the in-network benefit level when prior authorized to be received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services. Advanced cellular therapy products and their administration received from a provider that is not contracted with Cigna for the specific advanced cellular therapy product and related services are not covered.

Advanced Cellular Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized advanced cellular therapy product are covered, subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when:

- you are the recipient of a prior authorized advanced cellular therapy product;
- the term recipient is defined to include a person receiving prior authorized advanced cellular therapy related services during any of the following: evaluation, candidacy, event, or post care;
- the advanced cellular therapy products and services directly related to their administration are received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services; and
- the provider is not available within a 60 mile radius of your primary home residence.

Travel expenses for the person receiving the advanced cellular therapy include charges for: transportation to and from the advanced cellular therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver 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 mile radius of your primary home residence; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

HC-COV1326 01-24

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that may be 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 that, because of their characteristics as determined by Cigna, require a qualified licensed health care professional to administer or directly supervise administration.

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 coverage, the covered person may be required to try a specific Medical Pharmaceutical before trying others. Medical Pharmaceuticals administered in an Inpatient facility are reviewed per Inpatient review guidelines.

Cigna determines the utilization management requirements and other coverage conditions that apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to:

- Clinical factors, which may include but are not limited to Cigna’s evaluations of the site of care and the relative safety or relative efficacy of Medical Pharmaceuticals.
- Economic factors, which may include but are not limited to the cost of the Medical Pharmaceutical and assessments of cost effectiveness after rebates.

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.

Certain Medical Pharmaceuticals that are used for treatment of complex chronic conditions, are high cost, and are administered and handled in a specialized manner may be subject to additional coverage criteria or require administration by a participating provider in the network for the Cigna Pathwell Specialty Network. Cigna determines which injections, infusions, and implantable drugs are subject to these criteria and requirements.

The Cigna Pathwell Specialty Network includes but is not limited to contracted physician offices, ambulatory infusion centers, home and outpatient hospital infusion centers, and contracted specialty pharmacies. When the Cigna Pathwell Specialty Network cannot meet the clinical needs of the customer as determined by Cigna, exceptions are considered and approved when appropriate.

A complete list of those Medical Pharmaceuticals subject to additional coverage criteria or that require administration by a participating provider in the Cigna Pathwell Specialty Network is available at www.cigna.com/PathwellSpecialty.

The following are not covered under the plan, including but not limited to:

- Medical Pharmaceutical regimens that have a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s);
- Medical Pharmaceuticals newly approved by the Food & Drug Administration (FDA) up to the first 180 days following its market launch;
- Medical Pharmaceutical regimens for which there is an appropriate lower cost alternative for treatment.

In the event a covered Medical Pharmaceutical is not clinically appropriate, Cigna makes available an exception process to allow for access to non-covered drugs when Medically Necessary.

Cigna may consider certain Medical Pharmaceutical regimens as preferred when they are clinically effective treatments and the most cost effective. Preferred regimens are covered unless the covered person is not a candidate for the regimen and a Medical Necessity coverage exception is obtained.

HC-COV1186 01-23

Gene Therapy

Charges for gene therapy products and services directly related to their administration are covered when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when prior authorized to be received at In-Network facilities specifically contracted with Cigna for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered.

Gene Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy; and when the gene therapy products and services directly related to their administration are received at a participating In-Network facility specifically contracted with Cigna for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver 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.

HC-COV886 01-20

Clinical Trials

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

- 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; or
- the individual provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered.

The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that meets **any** of the following criteria:

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Health Care Research and Quality (AHRQ);

  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
  - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
- any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:
  - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
  - the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA);
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The plan does not cover any of the following services associated with a clinical trial:

- services that are not considered routine patient care costs and services, including the following:
  - the investigational drug, device, item, or service that is provided solely to satisfy data collection and analysis needs;
  - an item or service that is not used in the direct clinical management of the individual;
  - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- an item or service provided by the research sponsors free of charge for any person enrolled in the trial.
- travel and transportation expenses, unless otherwise covered under the plan, including but not limited to the following:
  - fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train;
  - mileage reimbursement for driving a personal vehicle;
  - lodging;
  - meals.
- routine patient costs obtained out-of-network when Out-of-Network benefits do not exist under the plan.

Examples of routine patient care costs and services include:

- radiological services.
- laboratory services.
- intravenous therapy.
- anesthesia services.
- Physician services.
- office services.
- Hospital services.
- Room and Board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

HC-COV1016 01-21

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by Cigna only to a person who:

- resides in a state that requires offering a conversion policy,
- is Entitled to Convert, and
- applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled to Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased but only if:

- you are not eligible for other individual insurance coverage on a guaranteed issue basis.
- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

If you retire, you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for other individual insurance coverage on a guaranteed issue basis, is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy

If you reside in a state that requires the offering of a conversion policy, the Converted Policy will be one of Cigna's current conversion policy offerings available in the state where you reside, as determined based upon Cigna's rules.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are Entitled to Convert, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

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Prescription Drug Benefits
The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a Deductible, Copayment or Coinsurance requirement for Covered Expenses for Prescription Drug Products.

You and your Dependents will pay 100% of the cost of any Prescription Drug Product excluded from coverage under this plan. The amount you and your Dependent pays for any excluded Prescription Drug Product to the dispensing Pharmacy, will not count towards your Deductible, if any, or Out-of-Pocket Maximum.

Coinsurance

The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.

Oral Chemotherapy Medication

Prescription oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered at participating pharmacies at 100% with no deductible and if applicable at non-participating pharmacies, is covered at the lower of the pharmacy cost share for oral chemotherapy medication or the out of network medical cost share for injectable/IV chemotherapy.

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Non-PPACA Preventive Medications Non-PPACA Preventive Medications used to prevent any of the following medical conditions and that are dispensed by a Pharmacy are not subject to the Deductible: • hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency		

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Patient Assurance Program Your plan offers additional discounts for certain covered Prescription Drug Products that are dispensed by a retail or home delivery Network Pharmacy included in what is known as the "Patient Assurance Program". As may be described elsewhere in this plan, from time to time Cigna may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your Out-of-Pocket Expenses for certain covered Prescription Drug Products for which Cigna directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna for certain covered Prescription Drug Products included in the Patient Assurance Program is applied or credited to a portion of your Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drug Products as set forth in The Schedule may be reduced in order for Patient Assurance Program discounts earned by Cigna to be applied or credited to the Copayment or Coinsurance, if any, as described above. For example, certain insulin product(s) covered under the Prescription Drug Benefit for which Cigna directly or indirectly earns a discount in connection with the Patient Assurance Program shall result in a credit toward some or all of your Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in The Schedule, for the insulin product. In addition, the covered insulin products eligible for Patient Assurance Program discounts shall not be subject to the Deductible, if any. Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum. Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum. Please note that the Patient Assurance Program discounts that Cigna may earn for Prescription Drug Products, and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any rebates or other payments that Cigna may earn from a pharmaceutical manufacturer for the same or other Prescription Drug Products. Except as may be noted elsewhere in this plan, you are not entitled to the benefit of those rebates or other payments earned by Cigna because they are unrelated to the Patient Assurance Program. Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drug Products included in the Patient Assurance Program and/or your Copayment or Coinsurance, if any for those eligible Prescription Drug Products, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to Cigna in connection with the Patient Assurance Program. More information about the Patient Assurance Program including the Prescription Drug Products included in the program, is available at the website shown on your ID card or by calling member services at the telephone number on your ID card.		
Maintenance Drug Products Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Designated Pharmacy or home delivery Network Pharmacy.		
Certain Preventive Care Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required.		

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy**
Tier 1 Generic Drugs on the Prescription Drug List	50%	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	50%	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	50%	In-network coverage only
Prescription Drug Products at Retail Designated Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Designated Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Designated Pharmacy**
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill.		
Note: In this context, a retail Designated Pharmacy is a retail Network Pharmacy that has contracted with Cigna for dispensing of covered Prescription Drug Products, including Maintenance Drug Products, in 90-day supplies per Prescription Order or Refill.		
Tier 1 Generic Drugs on the Prescription Drug List	50%	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	50%	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	50%	In-network coverage only
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy**
Tier 1 Generic Drugs on the Prescription Drug List	50%	In-network coverage only

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	50%	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	50%	In-network coverage only

Prescription Drug Benefits

Covered Expenses

Your plan provides benefits for Prescription Drug Products on the Prescription Drug List dispensed by a Pharmacy. Details regarding your plan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations, and Exclusions are provided below and/or are shown in The Schedule.

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule. Your benefits may vary depending on which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

Coverage under your plan's Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered pursuant to the, as applicable, Copayment or Coinsurance for the Prescription Drug Product when dispensed by a Network Pharmacy.

Prescription Drug List Management

Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. Determination of inclusion of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and utilization management requirements or other coverage conditions are based on a number of factors which may include, 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 the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product 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 status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). Please access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

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Limitations

Your plan includes a Brand Drug for Generic Drug dispensing program. This program allows certain Brand Drugs to be dispensed in place of the Therapeutic Equivalent Generic Drug at the time your Prescription Order or Refill is processed by a participating Pharmacy. Brand Drug for Generic Drug substitution will occur only for certain Brand Drugs included in the program. When this substitution program is applied, the participating Pharmacy will dispense the Brand Drug to you in place of the available Generic Drug. You will be responsible for payment of only a Generic Drug Copayment and/or Coinsurance, after satisfying your Deductible, if any.

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product 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 Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products 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 us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product 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 Product. The length of the authorization may depend on the diagnosis and the Prescription Drug Product. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product 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 Product 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 Product should be covered.

Step Therapy

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

Supply Limits

Benefits for Prescription Drug Products 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 Product 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 Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Specialty Prescription Drug Products

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

Designated Pharmacies

If you require certain Prescription Drug Products, including Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you may receive reduced or no coverage for the Prescription Drug Product. Refer to The Schedule for further information.

New Prescription Drug Products

New Prescription Drug Products may or may not be placed on a Prescription Drug List tier upon market entry. Cigna will use reasonable efforts to make a tier placement decision for a New Prescription Drug Product within six months of its market availability. Cigna's tier placement decision shall be based on consideration of, without limitation, the P&T Committee's clinical review of the New Prescription Drug Product and economic factors. If a New Prescription Drug Product 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 Product shall be covered at the applicable coverage tier as set forth in The Schedule.

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule, as well as any limitations or exclusions set forth in this plan. Please refer to

The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

Coinsurance

Your plan requires that you pay a Coinsurance amount for covered Prescription Drug Products as set forth in The Schedule. After satisfying any applicable annual Deductible set forth in The Schedule, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy and that is subject to a Coinsurance requirement will be the lowest of the following amounts:

- the amount that results from applying the applicable Coinsurance percentage set forth in The Schedule to the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

When a treatment regimen contains more than one type of Prescription Drug Products that are packaged together for your or your Dependent's convenience, any applicable Copayment or Coinsurance may apply to each Prescription Drug Product.

You will need to obtain prior approval from Cigna or its Review Organization for any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded. If Cigna or its Review Organization approves coverage for the Prescription Drug Product because it meets the applicable coverage exception criteria, the Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

The amount you or your Dependent pays for any excluded Prescription Drug Product 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 Product or other product.

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Exclusions

Coverage exclusions listed under the "Exclusions, Expenses Not Covered and General Limitations" section also apply to benefits for Prescription Drug Products. In addition, the exclusions listed below apply to benefits for Prescription Drug Products. When an exclusion or limitation applies to only certain Prescription Drug Products, you can access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

- coverage for Prescription Drug Products 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 Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products dispensed outside the jurisdiction of the United States, except as required for emergency or Urgent Care treatment.
- Prescription Drug Products 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 Drug Products 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 Drug Products.
- 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 or anti-aging purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth and fade cream products.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.

- any ingredient(s) in a compounded Prescription Drug Product 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 Product.
- certain Prescription Drug Products 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 Product 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.
- medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions unless specifically identified on the Prescription Drug List.
- smoking cessation medications except those required by federal law to be covered as Preventive Care Medications.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- medications that are experimental investigational or unproven as described under the “General Exclusion and Limitations” section of your plan’s certificate.

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Reimbursement/Filing a Claim

Retail Pharmacy

When you or your Dependents purchase your Prescription Drug Products through a Network Pharmacy, you pay any applicable Copayment, Coinsurance, or Deductible shown in The Schedule at the time of purchase. You do not need to file a claim form for a Prescription Drug Product obtained at a Network Pharmacy unless you pay the full cost of a Prescription Drug Product at a Network Pharmacy and later seek reimbursement for the Prescription Drug Product under the plan. For example, if you must pay the full cost of a Prescription Drug Product to the retail Network Pharmacy because you did not have your ID card, then you must submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. If, under this example, your payment to the retail Network Pharmacy for the covered Prescription Drug Product exceeds any applicable copay, then you will be reimbursed the difference, if any, between the applicable copay and the Prescription Drug Charge for the Prescription Drug Product.

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- charges which you are not obligated to pay and/or for which you are not billed. This exclusion includes, but is not limited to:
  - any instance where Cigna determines that a provider or Pharmacy did not bill you for or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.
  - charges of a non-Participating Provider who has agreed to charge you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.

In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:

- require you and/or any provider or Pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna,
- deny the payment of benefits in connection with the Covered Expense regardless of whether the provider or the Pharmacy represents that you remain responsible for any amounts that your plan does not cover, 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 provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover.
- charges or payment for healthcare-related services that violate state or federal law.

- 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 or Biologic therapies or devices that are determined by the utilization review Physician to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed.
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

  The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed, and is recognized for the treatment of cancer in any one of the following: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; U.S. Pharmacopeia Drug Information; or a U.S. peer-reviewed national professional journal.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for a continuous course of dental treatment for an Injury to teeth are also covered. Also, facility charges and charges for general anesthesia or deep sedation which cannot be administered in a dental office are covered when Medically Necessary.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- 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, unless otherwise covered under this plan.
- court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan.

- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of sperm, eggs or embryos are also excluded from coverage.
- reversal of male and female voluntary sterilization procedures.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy and premature ejaculation.
- medical and Hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under this plan.
- non-medical counseling and/or ancillary services including Custodial Services, educational 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.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Care Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Care Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with non-verbal communications, including communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames, contact lenses and associated services (exams and fittings) except the initial set after treatment of keratoconus or following cataract surgery.
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- acupuncture.
- all noninjectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered.
- membership costs and fees associated with health clubs, weight loss programs or smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- health and beauty aids, cosmetics and dietary supplements.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges related to an Injury or Sickness payable under worker's compensation or similar laws.
- massage therapy.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- for any charges related to care provided through a public program, other than Medicaid.
- for charges which would not have been made if the person did not have coverage.
- to the extent that they are more than Maximum Reimbursable Charges applicable to care, if any, received Out-of-Network.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- for expenses for services, supplies, care, treatment, drugs or surgery that are not Medically Necessary.
- for charges made by any Physician or Other Health Professional who is a member of your family or your Dependent's family.
- for expenses incurred outside the United States other than expenses for Medically Necessary emergency or urgent care while temporarily traveling abroad.

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Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

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

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

The amount of charges considered for payment under the Plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity’s contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

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

Reasonable Cash Value

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 by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee 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 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 an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, 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; and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

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

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new

benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare Plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 55 days of the request, the claim will be closed. If the requested information is subsequently received, the claim will be processed.

Coordination of Benefits with Medicare

If you, your spouse, or your Dependent are covered under this Plan and qualify for Medicare, federal law determines which Plan is the primary payer and which is the secondary payer. The primary payer always determines covered benefits first, without considering what any other coverage will pay. The secondary payer determines its coverage only after the Primary Plan has completed its determination.

When Medicare is the Primary Payer

Medicare will be the primary payer and this Plan will be the secondary payer, even if you don't elect to enroll in Medicare or you receive services from a provider who does not accept Medicare payments, in the following situations:

- COBRA or State Continuation: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to COBRA or state continuation of coverage.
- Retirement or Termination of Employment: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to your retirement or termination of employment.
- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has fewer than 100 employees.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has fewer than 20 employees.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan will be the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

When This Plan is the Primary Payer

This Plan will be the primary payer and Medicare will be the secondary payer in the following situations:

- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has 100 or more employees.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has 20 or more employees.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan is the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

IMPORTANT: If you, your spouse, or your Dependent do not elect to enroll in Medicare Parts A and/or B when first eligible, or you receive services from a provider who does not accept Medicare payments, this Plan will calculate payment based on what should have been paid by Medicare as the primary payer if the person had been enrolled or had received services from a provider who accepts Medicare payments. A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective.

Failure to Enroll in Medicare

If you, your spouse, or your Dependent do not enroll in Medicare Parts A and/or B during the person's initial Medicare enrollment period, or the person opts out of coverage, the person may be subject to Medicare late enrollment penalties, which can cause a delay in coverage and result in higher Medicare premiums when the person does enroll. It can also result in a reduction in coverage under Medicare Parts A and B. If you are planning to retire or terminate employment and you will be eligible for COBRA, state Continuation, or retiree coverage under this Plan, you should enroll in Medicare before you terminate employment to

avoid penalties and to receive the maximum coverage under Medicare. Please consult Medicare or the Social Security Administration for more information.

Assistance with Medicare Questions

For more information on Medicare's rules and regulations, contact Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. You may also contact the Social Security Administration toll-free at 1-800-772-1213, at www.ssa.gov, or call your local Social Security Administration office.

HC-COB275 01-21

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

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

Subrogation/Right of Reimbursement

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

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

Lien of the Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall 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.

- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

HC-SUB77 01-17

Payment of Benefits

Assignment and Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

You may, however, authorize Cigna to pay any healthcare benefits under this policy to a Participating or Non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or Non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Expenses directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or Non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a Non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the Non-Participating Provider.

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

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

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

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

Calculation of Covered Expenses

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

- the methodologies in the most recent edition of the Current Procedural terminology.

- the methodologies as reported by generally recognized professionals or publications.

HC-POB132 01-19

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date as determined by your Employer.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness for a period not longer than 12 months.

Dependents

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

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

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

Special Continuation of Medical Insurance For Dependents of Military Reservists

If your insurance ceases because you are called to active military duty in: the Florida National Guard; or the United States military reserves, you may elect to continue Dependent insurance. You must pay the required premiums to the Policyholder if you choose to continue Dependent insurance.

In no event will coverage be continued beyond the earliest of the following dates:

- the expiration of 30 days from the date the Employee's military service ends;
- the last day for which the required contribution for Dependent insurance has been made;
- the date the Dependent becomes eligible for insurance under another group policy. Coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is excluded from this provision;
- the date the Dependent becomes eligible for Medicare (this does not apply to Vision insurance);
- the date the group policy cancels;
- the date the Dependent ceases to be an eligible Dependent.

Reinstatement of Medical Insurance - Employees and Dependents

Upon completion of your active military duty in: the Florida National Guard; or the United States military reserves, you are entitled to the reinstatement of your insurance and that of your Dependents if continuation of Dependent insurance was not elected. Such reinstatement will be without the application of: any new waiting periods; or the Pre-existing Condition Limitation to any new condition that you or your Dependent may have developed during the period that coverage was interrupted due to active military duty.

Provisions Applicable to Reinstatement

- You must notify your Employer, before reporting for military duty, that you intend to return to Active Service with that Employer; and
- You must notify your Employer that you elect such reinstatement within 30 days after returning to Active Service with that Employer and pay any required premium.

Conversion Available Following Continuation

The provisions of the "Medical Conversion Privilege" section will apply when the insurance ceases.

HC-TRM131 01-18

Rescissions

Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

HC-TRM80 01-11

Medical Benefits Extension Upon Policy Cancellation

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

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date a succeeding carrier agrees to provide coverage without limitation for the disabling condition;
- the date you are no longer Totally Disabled;
- 12 months from the date the policy is canceled; or
- for pregnancy, until delivery.

Totally Disabled

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

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

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

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

HC-BEX42 04-11

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.

HC-FED1 10-10

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.

HC-FED4 10-10

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.

HC-FED96 04-17

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen 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)

Employee: The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through an Exchange (Marketplace) or the Employee seeks to enroll in a QHP through an Exchange 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 an Exchange for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

Family: A plan may allow an Employee to revoke family coverage midyear in order for family members ("related individuals") to enroll in a QHP through an Exchange (Marketplace). The related individual(s) must be eligible for a Special Enrollment Period to enroll in a QHP or seek to enroll in a QHP during the Marketplace's annual open enrollment period, and the disenrollment from the group plan corresponds to the intended enrollment of the individual(s) in a QHP for new coverage effective beginning no later than the day immediately following the last day of the original coverage. If the Employee does not enroll in a QHP, the Employee must select self-only coverage or family coverage including one or more already-covered individuals.

HC-FED111 01-23

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.

HC-FED67 09-14

Coverage for Maternity Hospital Stay

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

Please review this Plan for further details on the specific coverage available to you and your Dependents.

HC-FED11 10-10

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.

HC-FED12 10-10

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.

HC-FED13 10-10

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.

HC-FED93 10-17

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.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan 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.

HC-FED18 10-10

Claim Determination Procedures under ERISA

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 postservice basis, as described below:

Certain services require prior authorization in order to be covered. The Certificate 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 Certificate, 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 Certificate, in your provider's network participation documents as applicable, and in the determination notices.

Note: An oral statement made to you by a representative of Cigna or its designee that indicates, for example, a particular service is a Covered Expense, is authorized for coverage by the plan, or that you are eligible for coverage is not a guarantee that you will receive benefits for services under this plan. Cigna will make a benefit determination after a claim is received from you or your authorized representative, and the benefit determination will be based on, your eligibility as of the date services were rendered to you and the terms and conditions of the plan in effect as of the date services were rendered to you.

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 attempts to request a preservice determination, but 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.

Postservice 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.

HC-FED104 01-19

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

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

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

Who is Entitled to COBRA Continuation?

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

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

Secondary Qualifying Events

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

Disability Extension

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

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

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

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

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

Medicare Extension for Your Dependents

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

Termination of COBRA Continuation

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

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

Moving Out of Employer's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to emergency services only. Because the Plan does not provide out-of-network coverage, nonemergency services will not be covered under the plan outside of the Employer's service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

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

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper

notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

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

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

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

Grace periods for subsequent payments

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

You Must Give Notice of Certain Qualifying Events

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

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

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

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event.

COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's Bankruptcy

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

Conversion Available Following Continuation

If your or your Dependents' COBRA continuation ends due to the expiration of the maximum 18-, 29- or 36-month period, whichever applies, you and/or your Dependents may be entitled to convert to the coverage in accordance with the Medical Conversion benefit then available to Employees and the Dependents. Please refer to the section titled "Conversion Privilege" for more information.

Interaction With Other Continuation Benefits

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

HC-FED66 07-14

ERISA Required Information

The name of the Plan is:

ERISA Plan Name

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

ERISA Plan Sponsor Name
111 Street
City, FL 00000
000-000-0000

Employer Identification Number (EIN):	Plan Number:
00-0000000	501

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

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above

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

The Cigna Claim Office responsible for this Plan

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

The Plan's fiscal year ends on 12/31.

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

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

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

Discretionary Authority

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

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it.

Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

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

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

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

Statement of Rights

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this

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

HC-FED72 05-15

Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

HC-SPP4 04-10
V1

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.

HC-AAR1 01-17

When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted. We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

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

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free

number on your Benefit Identification card, explanation of benefits or claim form.

Florida Adverse Determination Medical Necessity Appeal

To initiate an Adverse Determination appeal, you must submit a request in writing to Cigna within 30 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 to write, you may ask Cigna to assist so that you may register your written appeal. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form. Your appeal will be reviewed and the decision made by individuals not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by an Internal Panel of health care professionals. For appeals involving Medical Necessity or clinical appropriateness, the Internal Panel will include at least one Physician in the same or similar specialty as the care under consideration, as determined by the Cigna Physician reviewer. For Adverse Determination Medical Necessity Appeals, we will acknowledge in writing that we have received your request and schedule a panel review. For preservice and concurrent care coverage determinations, the panel review will be completed within 30 calendar days and for post service claims, the panel review will be completed within 60 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Internal Panel to complete the review. You will be notified in writing of the Internal Panel's decision within five working days after the panel considers your request.

Expedited Medical Necessity Appeal

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 function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. The Cigna Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional. Please note that if you submit your written request within 30 days of receiving an initial denial notice, the Florida Adverse Determination Medical Necessity Appeal process described will apply. For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a 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. If an issue does not qualify for the Expedited Medical Necessity Appeal process, you may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal. Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may present your situation to the Committee in person or by conference call. For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage. If an issue does not qualify for the Expedited Medical Necessity Appeal process, 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 function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing

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

Appeal to the State of Florida

You have the right to contact the state regulators for assistance at any time. The state regulators may be contacted at the following addresses and telephone numbers:

The Statewide Provider and Subscriber Assistance Panel
Fort Knox Building One, Room 303
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456 or 850-921-5458
The Agency for Health Care Administration
Fort Knox Building One, Room 303
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456
The Department of Insurance
State Treasurer's Office
State Capitol, Plaza Level Eleven
Tallahassee, FL 32308
1-800-342-2762

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: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) 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; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and 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. You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

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

Legal Action

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

HC-APL380 01-20

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis as determined by your Employer on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1095 12-17

Ambulance

Licensed ambulance transportation services involve the use of specially designed and equipped vehicles for transporting ill or injured patients. It includes ground, air, or sea transportation when Medically Necessary and clinically appropriate.

HC-DFS1406 01-20

Ancillary Charge

An additional cost, outside of plan cost sharing detailed in The Schedule of Prescription Drug Benefits, which may apply to some Prescription Drug Products when you request a more expensive Brand Drug when a lower cost, Therapeutic Equivalent, Generic Drug is available. The Ancillary Charge is the amount by which the cost of the requested Brand Drug exceeds the cost of the Generic Drug.

HC-DFS1562 01-21

Biologic

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS840 10-16

Biosimilar

A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS841 10-16

Brand Drug

A Prescription Drug Product that Cigna identifies as a Brand Drug product 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.

HC-DFS842 10-16

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 effect changes regarding coverage treatment of Prescription Drug Products and Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, changes regarding tier placement and application of utilization management to Prescription Drug Products and Medical Pharmaceuticals.

HC-DFS1563 10-21

Charges

The term charges means 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.

HC-DFS1193 01-19

Convenience Care Clinic

Convenience Care Clinics are staffed by nurse practitioners and physician assistants and offer customers convenient, professional walk-in care for common ailments and routine services. Convenience Care Clinics have extended hours and are located in or near easy-to-access, popular locations (pharmacies, grocery and free-standing locations) with or without appointment.

HC-DFS1643 01-22

Custodial Services

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 service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

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

HC-DFS4 04-10
V1

Dependent – For Medical Insurance

Dependents are:

- your lawful spouse; and
- any child of yours:
  - who is less than 26 years old.
  - from 26 years until the end of the calendar year in which the child reaches the age of 30, provided the child is unmarried and does not have a dependent of his own, is a Florida state resident or a full-time or part-time student, and is not covered under a plan of his own or entitled to benefits under Title XVIII of the Social Security Act. Cigna may require such proof at least once each year until the end of the calendar year in which he attains age 30; and
  - who is 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence may be required to be submitted to the plan as a condition of coverage after the date the child ceases to qualify above. However, if a claim is denied, proof must be submitted by the Employee that the child is and has continued to be mentally or physically handicapped.

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. A child also includes a foster child or a child placed in your custody by a court order from the date of placement in the home. Coverage is not required if the adopted or foster child is ultimately not placed in your home. It also includes:

- a stepchild or a child for whom you are the legal guardian;
- a child born to an insured Dependent child of yours until such child is 18 months old.

Benefits for a Dependent child will continue until the last day of the calendar year in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent or Dependent spouse unless the Dependent or Dependent spouse declines Employee coverage.

A child under age 26 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee.

No one may be considered as a Dependent of more than one Employee.

HC-DFS1685 01-23

Designated Pharmacy

A Network Pharmacy that has entered into an agreement with Cigna, or with an entity contracting on Cigna's behalf, to provide Prescription Drug Products or services, including, without limitation, specific Prescription Drug Products, to plan enrollees on a preferred or exclusive basis. For example, a Designated Pharmacy may provide enrollees certain Specialty Prescription Drug Products that have limited distribution availability, provide enrollees with an extended days' supply of Prescription Drug Products or provide enrollees with Prescription Drug Products on a preferred cost share basis. A Pharmacy that is a Network Pharmacy is not necessarily a Designated Pharmacy.

HC-DFS1564 01-21

Emergency Medical Condition

Emergency Medical Condition means 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.

HC-DFS1765 01-23

Emergency Services

Emergency Services means, 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.

HC-DFS1763 01-23

Employee

The term Employee means an Employee as determined by your Employer who is currently in Active Service.

HC-DFS1094 12-17

Employer

The term Employer means the policyholder and those affiliated Employers whose Employees are covered under this Policy.

HC-DFS1566 01-21

Essential Health Benefits

Essential health benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

HC-DFS411 01-11

Expense Incurred

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

HC-DFS10 04-10
V1

Free-Standing Surgical Facility

The term Free-Standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

A Free-Standing Surgical Facility, unless specifically noted otherwise, is covered with the same cost share as an Outpatient Facility.

HC-DFS1407 01-20

Generic Drug

A Prescription Drug Product that Cigna identifies as a Generic Drug product 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 products 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.

HC-DFS846 10-16

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

HC-DFS51 04-10
V1

Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

HC-DFS52 04-10
V1

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

HC-DFS53 04-10
V1

Hospital

The term Hospital means:

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

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

HC-DFS1429 01-20

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

HC-DFS807 12-15

Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

Maintenance Drug Product

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 member services at the telephone number on your ID card.

HC-DFS847 10-16

Maximum Reimbursable Charge - Medical

The Maximum Reimbursable Charge does not apply to Emergency Services.

The Maximum Reimbursable Charge for covered services for Open Access Plus In-Network 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 Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS1642 01-22
V2

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.

HC-DFS16 04-10
V1

Medical Pharmaceutical

Medical Pharmaceuticals are used for treatment of complex chronic conditions, are administered and handled in a specialized manner, and may be high cost. Because of their characteristics, they require a qualified Physician to administer or directly supervise administration. Some Medical Pharmaceuticals may initially or typically require Physician oversight but subsequently may be self-administered under certain conditions specified in the product's FDA labeling.

HC-DFS1751 01-24

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:

- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or Other Health Professional;
- 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
- 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.

In determining whether health care services, supplies, or medications are Medically Necessary, the Medical Director or

Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

HC-DFS1411 01-20

Medicare

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

HC-DFS17 04-10
V1

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Room and Board, made by a Hospital for medical services and supplies actually used during Hospital Confinement.

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

HC-DFS1409 01-20

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.
- been designated as a Network Pharmacy for the purposes of coverage under your Employer’s plan.

This term may also include, as applicable, an entity that has directly or indirectly contracted with Cigna to arrange for the provision of any Prescription Drug Products the charges for which are Covered Expenses.

HC-DFS1198 01-19

New Prescription Drug Product

A Prescription Drug Product, or new use or dosage form of a previously FDA-approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or newly-approved use or dosage form becomes available on the market following approval by the U.S. Food and Drug Administration (FDA) and ending on the date Cigna makes a Prescription Drug List coverage status decision.

HC-DFS1568 01-21

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

HC-DFS22 04-10
V1

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

HC-DFS1412 01-20

Other Health Professional

The term Other Health Professional means 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 Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS1413 01-20

Participating Provider

The term Participating Provider means a person or entity that has a direct or indirect contractual arrangement with Cigna to

provide covered services and/or supplies, the Charges for which are Covered Expenses. It includes 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, the Charges for which are Covered Expenses.

HC-DFS1194 01-19

Patient Protection and Affordable Care Act of 2010 ("PPACA")

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

HC-DFS412 01-11

Pharmacy

A duly licensed Pharmacy that dispenses Prescription Drug Products in a retail setting or via home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drug Products through mail order.

HC-DFS851 10-16

Pharmacy & Therapeutics (P&T) Committee

A committee comprised of Physicians and an independent pharmacist that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals or Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage determinations made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

HC-DFS1570 01-21

Physician

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

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

HC-DFS25 04-10
V1

Prescription Drug Charge

The Prescription Drug Charge is the amount that, prior to application of the plan's cost-share requirement(s), is payable by Cigna to its Pharmacy Benefit Manager for a specific covered Prescription Drug Product dispensed at a Network Pharmacy, including any applicable dispensing fee and tax. The "Pharmacy Benefit Manager" is the business unit, affiliate, or other entity that manages the Prescription Drug Benefit for Cigna.

HC-DFS1191 01-19

Prescription Drug List

A list that categorizes Prescription Drug Products covered under the plan's Prescription Drug Benefits into coverage tiers. This list is developed by Cigna based on clinical factors communicated by the P&T Committee and adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.

HC-DFS1752 01-24

Prescription Drug Product

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. For the purpose of benefits under the plan, this definition may also include products in the following categories if specifically identified on the Prescription Drug List:

- Certain durable products and supplies that support drug therapy;

- Certain diagnostic testing and screening services that support drug therapy;
- Certain medication consultation and other medication administration services that support drug therapy;
- Certain digital products, applications, electronic devices, software and cloud-based service solutions used to predict, detect and monitor health conditions in support of drug therapy.

HC-DFS1645 01-22

Prescription Order or Refill

The lawful directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

HC-DFS856 10-16

Preventive Care Medications

The Prescription Drug Products 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:

- 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.
- 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.
- 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.

HC-DFS857 10-16

Primary Care Physician

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice OB/GYN or pediatrics; and who has been voluntarily selected by you and is contracted as a Primary Care Physician with, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

HC-DFS40 04-10
V1

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

HC-DFS26 04-10
V1

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 members who perform utilization review services.

HC-DFS808 12-15

Room and Board

The term Room and Board includes all charges made by a Hospital for room and meals and for all general services and activities needed for the care of registered bed patients.

HC-DFS1408 01-20

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

HC-DFS50 04-10
V1

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

HC-DFS31 04-10
V1

Specialist

The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

HC-DFS33 04-10
V1

Specialty Prescription Drug Product

A Prescription Drug Product or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Prescription Drug Product or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug Product or Medical Pharmaceutical has a high acquisition cost; and, whether the Prescription Drug Product 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 Product 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 Product or Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products 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 Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-DFS858 10-16

Spinal Manipulation Care

The term Spinal Manipulation Care means 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.

HC-DFS1684 01-23

Stabilize

Stabilize means, 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.

HC-DFS1767 01-23

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

HC-DFS54 04-10
V1

Therapeutic Alternative

A Prescription Drug Product or Medical Pharmaceutical that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

HC-DFS859 10-16

Therapeutic Equivalent

A Prescription Drug Product or Medical Pharmaceutical that is a pharmaceutical equivalent to another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

HC-DFS860 10-16

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which 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. Such care includes, but is 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.

HC-DFS34 04-10
V1

Usual and Customary (U&C) Charge

The usual fee that a Pharmacy charges individuals for a Prescription Drug Product (and any services related to the dispensing thereof) without reference to reimbursement to the Pharmacy by third parties. The Usual and Customary (U&C) Charge includes a dispensing fee and any applicable sales tax.

HC-DFS861 10-16