PPO Option
Under the Sodexo, Inc. Medical Plan

Summary Plan Description

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This booklet contains a summary of the PPO (Preferred Provider Organization) Option under the Sodexo, Inc. Medical Plan (referred to as the Plan) sponsored by Sodexo, Inc., (referred to as the Company). The PPO Option is administered by Cigna Health and Life Insurance Company (referred to as Cigna) and uses the Cigna Open Access Plus/CareLink product and Cigna's nationwide Network of hospitals, doctors and other Providers and facilities. The Plan Administrator is the Corporate Benefits Department, Sodexo, Inc.

All previously issued summary plan descriptions and summary of material modifications are obsolete.

NOTA: Si usted tiene alguna pregunta con respecto a este folleto o al Plan, comuniquese con la persona encargada de los beneficios donde usted trabaja. Para pedir una copia de est librete en Espanol comuniquese al 877 633 9837.

FOR MORE INFORMATION

About this topic...	Contact...
• Questions about specific situations	Cigna — 800 909 2227, 24/7 — www.myCigna.com
• Prescription Drug Information	Medco — 800 903 7968 — www.medco.com
• General questions about the Plan, including eligibility	—877 633 9837 — https://mysodexobenefits.com

Are Your Records Up-To-Date?

Please contact your Human Resources representative or the person who handles your payroll whenever your personal information changes. This includes your name, marital status or Social Security number.

To change your street address, go to www.IamSodexo.com > Employee Self Service, or call 877 PAYSDXO (877 729 7396).

ABOUT THE PREFERRED PROVIDER ORGANIZATION PLAN (PPO) OPTION

Sodexo offers a nationwide PPO (Preferred Provider Organization) Option under the Sodexo Medical Plan that is administered by Cigna using Cigna's Open Access Plus/CareLink product and its nationwide Provider Network. The Plan offers In-Network and Out-of-Network benefit options. With Cigna, you can:

- See the doctor of your choice (In- or Out-of-Network) and receive benefit coverage
- Go to a Specialist without a referral
- Receive a higher level of benefits by seeing a participating In-Network medical Provider
- Generally file claim forms only if you go to an Out-of-Network medical Provider

ENROLLING IN THE PPO OPTION

To enroll in the PPO Option or to make changes to your benefits, you must contact Sodexo Benefits. You will need to use your Social Security number (SSN) or Employee ID and personal identification number (PIN) to enroll. If you are eligible, you can contact Sodexo Benefits to:

- Enroll in the PPO Option
- Add or cancel dependents
- Cancel coverage
- Get answers to general questions about the PPO Option
- Get answers to questions about most other Company-sponsored benefits plans

There are four ways to contact Sodexo Benefits:

- By visiting the website — https://mysodexobenefits.com
- By calling the toll-free number — 877 633 9837
- By calling the TDD (Telephone Device for the Deaf) line — 800 551 3117
- By calling the international line if you are out of the country — 904 443 6535

YOUR PIN

Whenever you use your PIN to make benefit choices or changes through Sodexo Benefits, you are authorizing the Company to adjust your benefits and associated pay. Using your PIN is the same as if you signed your name on a form, and you are accepting all terms and conditions of the plans in which you enroll. You are the only person who should use your PIN. Keep it in a safe place and do not share it with others.

MAKING BENEFIT CHANGES

If you need to...	Make changes within...	Change will take effect...
Add coverage or dependents	45 days of qualifying event	On the Saturday following your change
Cancel coverage or dependents	60 days of qualifying event	On the Friday following your change

Eligibilty

ELIGIBLE EMPLOYEES

You can participate in the PPO Option if it is offered at your unit. You must be one of the following:

- A non-temporary, active salaried employee (class 1-4)
- A non-temporary, full-time frontline (class 6) employee working at least 30 hours per week for six or more weeks out of each quarter

ELIGIBLE DEPENDENTS

The table below will help you determine whom you can enroll for coverage as a dependent. For detailed information on enrolling your dependents, see the *Qualifying Events* section.

Collective Bargaining

Certain employees are subject to collective bargaining agreements and are not eligible to participate in this Plan, but may receive benefits in accordance with the applicable collective bargaining agreement.

CAN I ENROLL MY…?		
Spouse*	Legally married (including common law Spouse—documentation required)	Yes
	Divorced or legally separated	No
	Covered as an employee in any medical plan sponsored by Sodexo	No
	In active military service	No
	If not living with me and not a permanent U.S. resident	No
Domestic Partner**	See below. Affidavit required.	Yes
Children (under 26 years old)	Natural or adopted	Yes
	Under my legal guardianship	Yes
	Under my legal custody	Yes
	Stepchildren (whether living with me or not)	Yes
	Under a Qualified Medical Child Support Order (QMCSO)	Yes
	Of my Domestic Partner	Yes
	Covered by another parent in any medical plan sponsored by Sodexo	No
	Covered as an employee in any medical plan sponsored by Sodexo	No
	If they are married	Yes
	In active military service	No
	If not living with me and not permanent U.S. residents	No
	Foster children	No
Children	Disabled and 26 years or older	Call 877 633 9837
Other Relatives	Sisters, brothers, parents, in-laws, grandchildren, Spouse and/or children of your married child, etc.	No

*See the *Glossary of Terms* section for a definition of Spouse.

**To qualify for Domestic Partner status, the employee and partner must meet all of the following criteria:

- Declare they are each other's sole Domestic Partner and have a committed relationship intended to be of indefinite duration
- Not be legally married to anyone else
- Be at least 18 years old
- Not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which they legally reside
- Reside together in the same residence and intend to do so indefinitely
- Be jointly responsible for each other's common welfare and share financial obligations

Sodexo recognizes Domestic Partners of same sex and opposite sex in all 50 states.

CHILDREN

Children under the age of 26 can be covered under the PPO Option regardless of marital, residential, student or financial status or whether you list them as a dependent for income tax purposes. To meet eligibility requirements, children must be:

- Your biological child(ren)
- Legally adopted child(ren)
- Stepchild(ren)
- Any other child(ren) for whom you are the legal guardian or for whom you obtain legal custody in accordance with the laws of the state in which you reside
- Your Domestic Partner's child(ren)
- The child(ren) covered under a Qualified Medical Child Support Order (QMCSO) that requires you to provide him or her with health care coverage. This does not include a QMCSO order for your Spouse's children.
- Disabled child(ren) – Can be covered beyond age 26 if they meet the eligibility requirements defined in the box below. Call 877 633 9837 for additional information on eligibility.

Not Eligible (unless meeting the criteria for eligibility as outlined above):

- Children in active military service
- Children covered by another parent in the Sodexo sponsored medical plan
- Children covered as an employee in the Sodexo sponsored medical plan
- Your grandchild (whether or not the child of a covered dependent child)
- The Spouse of your dependent child
- Your sister or brother
- Your niece or nephew

Disabled Children

Disabled children age 26 and older must be wholly dependent on you for financial support to be covered as a dependent. They must have been enrolled and on your coverage prior to their 26th birthday for coverage to continue after the age of 26.

DUPLICATE COVERAGE

If you and your Spouse both work for Sodexo, you can choose to have coverage on your own or as a dependent of your Spouse, but you cannot have both. Because your medical plan contributions are made on a Before-Tax basis, coverage may be changed only during Annual Enrollment, unless you experience a qualifying event.

- If you and your Domestic Partner both work for Sodexo, you can choose to have coverage on your own or through your Domestic Partner, but you cannot have both.
- If you are an employee *and* a dependent of an employee, you *cannot* have duplicate coverage as an employee *and* a dependent.

EXAMPLE

Suppose you are 25 years old and both you and your mother work for Sodexo. You may choose to be covered under your mother's plan as a dependent (until your 26th birthday), or you can have your own coverage. You cannot have both.

Qualified Medical Child Support Order (QMCSO)

Any eligible dependent child may be added to your coverage according to the provisions of a Qualified Medical Child Support Order, provided that the order complies with the written administrative procedures established to determine whether a "medical child support order" is a "Qualified Medical Child Support Order" as defined by ERISA (The Employee Retirement Income Security Act of 1974). A Qualified Medical Child Support Order is a judgment, decree or order issued by a court or through an administrative process that has the force and effect of state law providing for child support or health benefits coverage.

DEPENDENT SOCIAL SECURITY NUMBERS

To comply with federal mandates on reporting of Plan Participant information to the Centers for Medicare and Medicaid Services, Sodexo must report Social Security numbers (SSNs) for all Plan Participants, including dependents. Make sure the dependents you have enrolled in the PPO Option have their SSNs on file with Sodexo Benefits. Also, be sure to call 877 633 9837 immediately to cancel any dependents who no longer meet the eligibility requirements for coverage under the Plan. If for any reason you do not have Social Security numbers for your dependents, call 877 633 9837 to determine your options.

CONTRIBUTIONS

Your personalized Fact Sheet indicates how much you pay for PPO Option coverage. Your contributions are deducted from each paycheck you receive on a Before-Tax basis. By paying for PPO Option coverage on a Before-Tax basis, you reduce your taxable income. This can help you save on federal and most state income taxes, as well as Social Security taxes. However, the federal government places restrictions on when you may cancel or change your coverage. You may only cancel or change your (or your dependent's) coverage during the Plan Year if you have a qualifying event. For more details, see the *Qualifying Events* section. Review your pay statement to verify that your PPO Option contributions are deducted correctly.

Domestic Partners

Because Domestic Partners and their children are not considered tax dependents by the IRS, contributions for their coverage are deducted on an After-Tax basis. Call 877 633 9837 for more information.

NICOTINE SURCHARGE

If you use tobacco products, you will pay a nicotine surcharge* of $11.54 per week ($600 per year) in addition to your regular medical plan premiums.

Nicotine Use is defined as the use of tobacco products within the last 12 months in such forms as cigarettes, pipes, cigars, snuff or chewing tobacco. With respect to the Sodexo Medical Plan, using smoking cessation products that contain nicotine is not considered Nicotine Use.

When you enroll for coverage, you will be asked to designate whether or not you are a Nicotine User. If you acknowledge that you use tobacco products, you will pay the surcharge noted above in addition to your medical plan premiums.

You can eliminate the surcharge at any time by: (a) submitting a signed Nicotine Status Change Affidavit, which can be obtained by calling 877 633 9837 or visiting https://mysodexobenefits.com; **and** (b) enrolling in a smoking cessation program such as the **Quit Today® Program** offered free of charge to PPO Option Participants age 18 and over.

If you are medically unable to quit due to nicotine addiction, you can eliminate the surcharge by filling out the Affidavit and supplying documentation from your medical Provider.

If you use a tobacco product, Sodexo can help you become a non-user. See the box on the next page for resources to support your effort to quit. Once you begin the process to quit using tobacco products, you'll be able to save money by electing to eliminate the nicotine surcharge in accordance with the steps described above.

Note: The Nicotine Surcharge is not applicable to employees covered under a collective bargaining agreement. If you have questions regarding whether this applies to you, call 877 633 9837.

Resources to Help You Quit Using Nicotine Products

Quit Today® Program
The PPO Option offers resources to help you quit smoking and get on a path to better health. This program is offered free to PPO Option Participants age 18 and over.

The tobacco cessation program includes:

- Personal Coaching – including setting up a personalized quit plan with a counselor
- Quitting Tools – including a workbook and online diary and exercises to help your progress
- Savings Calculator – personalized based on your usage, shows your savings by quitting
- Over-the-counter nicotine replacement therapy (NRT) – can be ordered through an online form (gum or patch) and delivered to your home at no cost to you

Learn more at www.myCigna.com or call 800 909 2227.

Note: Prescribed nicotine replacement drugs are not available through the program but may be available through the Medco Prescription Drug Program.

IF YOU STOP MAKING CONTRIBUTIONS

You risk cancellation of your (and your dependents') coverage if you do not make payments for the proper amount. You will receive a notice at your home when your payments fall three (3) weeks behind. To keep your coverage, you must promptly pay this amount in full; partial payments will not be accepted. If you have not paid the amount due by the end of the sixth week, your benefits will be canceled back to your last week of paid coverage and you will not be able to re-enroll until the next Annual Enrollment period. If your benefits are canceled for nonpayment, any medical bills incurred after your cancel date are your responsibility—the Plan is not liable.

However, if you are on a Military Leave of Absence, a leave covered by the Family and Medical Leave Act (FMLA), or an FMLA-like leave, and you lose coverage because you stop making contributions, call the person who handles your benefits or 877 633 9837 for information regarding your reinstatement rights.

Insufficient Contributions

If your wages will not cover the amount of contributions required by the Plan, see the person who handles your benefits. You are responsible for keeping your benefit payments up to date and may need to send additional funds to one of the addresses listed below:

First Class Mail:
Sodexo, Inc.
Benefits Administration
P.O. Box 352
Buffalo, NY 14240
800 828 7762 x58604

Overnight Mail:
Sodexo, Inc.
Benefits Administration
10 Earhart Drive
Williamsville, NY 14221

CONTRIBUTIONS MADE IN ERROR

If your or your covered dependents' participation in the Plan stops but contributions continue to be deducted from your paycheck, you should call 877 633 9837 immediately. You will be reimbursed for any deductions withheld in error. There are certain circumstances where you may not receive a refund on premiums—for example, if you did not notify Sodexo Benefits within 60 days of the event that caused you or your dependents to lose coverage. If this occurs, you may not receive a refund of the premiums paid on your dependents' behalf. Contributions made in error will not entitle you or your dependents to extended coverage under the Plan. You will be responsible for repaying the Plan for any benefits that are paid on your behalf after coverage has ended.

AFTER-TAX CONTRIBUTIONS FOR DOMESTIC PARTNER COVERAGE

PPO Option contributions for Domestic Partners and Domestic Partner's children are made on an After-Tax basis. This is accomplished through the use of Imputed Income. Benefit contributions are taken out of your paycheck on a Before-Tax basis but reflected as income on your W-2 forms.

PPO Option Before-Tax Contributions and Company contributions toward Domestic Partner coverage will be considered taxable income to you and will be subject to Social Security, Medicare, and federal income tax withholding, and state and local income tax withholding where applicable. This amount will be reported to the IRS as part of your wages on each pay stub and additional income taxes and FICA (Social Security and Medicare) taxes will be withheld from your paycheck on this Imputed Income.

LEAVE OF ABSENCE (LOA)

If you take a Leave of Absence, you may continue or cancel coverage for yourself and your eligible dependents. To continue your coverage, you must make your required contributions while on leave. Contact the person who handles your benefits before your leave begins. To cancel your coverage while on leave, call 877 633 9837. If you voluntarily cancel your coverage, you may not be eligible to re-enroll in your previous plan until the next Annual Enrollment. Coverage will end on the Friday coinciding with or following your call to cancel coverage.

PROPER LEAVE OF ABSENCE PROCESSING

Proper Leave of Absence processing can protect your employment status. Contact the person who handles your payroll if you are going to be away from work for any reason, regardless of the period of time. Request to be placed on an authorized Leave of Absence if your reason for missing work qualifies under the Company's Leave of Absence policy. Failure to follow these guidelines may result in termination of your employment.

MAKING CONTRIBUTIONS WHILE ON LEAVE

If you choose to continue coverage, you must make direct payments while on leave. The first payment must equal at least four weeks of contributions and must be received before the end of the second week of absence. Any further payments must equal at least four weeks of contributions—or the number of weeks you expect to be on Leave of Absence, if less than four weeks—and be submitted monthly. You pay in advance for the following month's coverage (a month with five weeks requires five weeks of payment in advance).

Participants on an approved Leave of Absence will be mailed an FMLA Leave of Absence packet, which includes important information on how to maintain your benefits while on leave. If you do not receive such mailing within two weeks of the start of your leave, please contact your manager for further information.

If you are a Nicotine User, you also will need to pay the surcharge while on leave. If you fail to pay both the medical premium and the surcharge, you will be in jeopardy of having your PPO Option coverage canceled for non-payment.

Send your check or money order to one of the addresses listed below:

First Class Mail:

Sodexo, Inc.
Benefits Administration
P.O. Box 352
Buffalo, NY 14240
800 828 7762 x58604

Overnight Mail:

Sodexo, Inc.
Benefits Administration
10 Earhart Drive
Williamsville, NY 14221

Your check or money order should be made payable to Sodexo.

Do ***not*** write your Social Security number on your check or money order. Please include your name (or the name of the covered employee if you are a relative or friend), your employee ID and/or the last four digits of your Social Security number, and a contact number on a separate sheet of paper (do not write it on your payment) along with instructions on what plans you want the payment to cover (names of the plans you are paying for). Insert this sheet in the same envelope with your payment. If your coverage is canceled for nonpayment, you will not be able to re-enroll until the next Annual Enrollment unless you have a qualifying event.

If your address changes during your Leave of Absence, please update your address online at www.IamSodexo.com > Employee Self Service or call the service center at 877 729 7396.

MILITARY, FMLA AND FMLA-LIKE LEAVE

Before you go on an authorized Leave of Absence covered by the Family and Medical Leave Act (FMLA), FMLA-like leave or a Military Leave of Absence, contact the person who handles your benefits for information on:

- Continuing your coverage
- Canceling your coverage
- Re-enrolling for coverage when you return to work at the end of your Military Leave, FMLA or FMLA-like leave, as applicable

If you are on a Military Leave of Absence, a Leave of Absence covered by the Family and Medical Leave Act or an FMLA-like Leave of Absence and you lose coverage because of voluntary cancellation, please call 877 633 9837 before or upon your return to work for information regarding your reinstatement rights. You must call within 45 days of your return to work date.

If you don't elect to continue coverage during your military service, you may have the right to be reinstated in Sodexo's health plans when you are re-employed, generally without any waiting periods or exclusions (e.g., Pre-Existing Condition exclusions) except for service-connected illnesses or injuries.

CERTIFICATE OF COVERAGE—HIPAA NOTICE

A certificate of coverage, also known as a HIPAA Notice, is required by the Health Insurance Portability and Accountability Act of 1996 and provides evidence of group medical coverage. You (or your covered dependent) will be sent a certificate of coverage:

- When you (or your covered dependent) lose your medical coverage
- When you (or your covered dependent) become ineligible for COBRA coverage
- Upon request, within 24 months of termination of coverage

Keep the certificate in your personal files for future reference. You may need it if you apply for other medical coverage that limits benefits for Pre-Existing Conditions.

ABOUT YOUR COVERAGE

WHEN YOUR COVERAGE IS EFFECTIVE

Newly Hired Employees

If you are a newly hired employee, your eligibility period and the date your coverage begins are listed on your personalized Fact Sheet. If you enroll within your eligibility period, coverage will begin on your coverage effective date.

Newly Eligible Employees

If a change in employment status qualifies you for the PPO Option, your eligibility period is generally the 45 days following your status change. If you call 877 633 9837 within 45 days of your status change, your coverage will begin on the Saturday following the day you call.

Your Dependents

Coverage for your dependents becomes effective at the same time your coverage becomes effective if you request employee plus-one or family-level coverage when you enroll. If you have employee-only coverage and would like to change to employee plus-one or family-level coverage during the year, call 877 633 9837 when the following events occur:

- Marriage — You must enroll your Spouse within 45 days of marriage. If you call 877 633 9837 before you get married, coverage will become effective on your marriage date. If you contact Sodexo Benefits within the 45 days after your marriage, coverage will become effective on the Saturday following the day you enroll.
- Birth — You must enroll your newborn within 45 days of birth. Coverage will become effective as of the date of birth. If the addition of your newborn changes your level of coverage to employee plus one or family, you will be required to pay the difference in cost between the two levels of coverage retroactively to the baby's date of birth.
- Adoption — You must enroll your adopted child within 45 days of the date you assumed legal custody. You may choose whether you want coverage to become effective as of the date of adoption or the date the child was placed in your home. A copy of the placement papers will be required.

If you already have employee plus-one or family-level coverage when any of these events occur, call 877 633 9837 to add your dependent to your coverage. You must always call to add newly eligible dependents within 45 days of the qualifying event, regardless of your current level of coverage.

Your Domestic Partner and Your Domestic Partner's Children

Domestic partners and their children can only be enrolled during Annual Enrollment or when the employee is newly eligible (as a new hire, for example), unless you experience a qualifying event. Coverage for your Domestic Partner and the children of your Domestic Partner becomes effective at the same time your coverage becomes effective if you request employee plus one or family-level when you enroll.

The children of your Domestic Partner are eligible for coverage if they meet the following criteria:

- The Domestic Partner is the child's biological or adoptive parent, or court-appointed guardian
- The child is under age 26

If a child is born to or adopted by you and your Domestic Partner and you are both already enrolled in the Plan, you should call 877 633 9837 within 45 days after the birth or adoption date.

If you and your Domestic Partner legally marry, you must call 877 633 9837 within 45 days of the marriage date.

Late Enrollees

If you do not enroll yourself or your dependents in the Plan within the eligibility period, you and/or your dependents will not be eligible to choose coverage until the next Annual Enrollment period and coverage will not begin until the first day of the next Plan Year.

WHEN YOU CAN CHANGE YOUR COVERAGE

After you enroll in the PPO Option, your coverage generally remains in effect for the entire Plan Year unless you have a qualifying event. A qualifying event is a work or life occurrence that affects your benefits (such as marriage, divorce, having a baby, or a change in your eligibility) and entitles you to make changes to your coverage during the Plan Year. When you have a qualifying event, you may be able to change your coverage by either adding or canceling coverage for yourself and/or your dependents. Because your Plan contributions are made on a Before-Tax basis, any changes in coverage must be made during Annual Enrollment or as a result of a qualifying event.

Change in Coverage

In all cases, the change in your coverage must be directly related to your qualifying event. For example, if you have a baby, you may only add your new child to your coverage, you cannot add other dependents to coverage.

If you do not call 877 633 9837 to cancel coverage when a dependent becomes ineligible, you will be responsible for repaying the Plan for any benefits that are paid on behalf of your ineligible dependent after he becomes ineligible. In addition, you or your eligible dependent may not receive an offer letter to continue coverage.

If your coverage under another plan was lost because of fraud, failure to make the necessary contributions, or voluntary cancellation, you may not be eligible to enroll in the PPO Option.

Notification Requirement

You must call 877 633 9837 within 60 days of the date your covered dependent loses his/her eligibility for coverage (for example you and your Spouse become legally separated). Notification made within this 60 day time period will allow the dependent to be offered COBRA or continuation coverage. See the *Continued Coverage* section on page 46.

QUALIFYING EVENTS

You may be able to enroll yourself and/or your dependents for coverage within 45 days of a qualifying event, or cancel coverage for yourself and/or your dependents within 60 days of a qualifying event. Qualifying events include:

- Your marriage—Call before your marriage for coverage on the day you marry or call within 45 days of your marriage and coverage will begin on the Saturday following your call. You can enroll your Spouse and any children who become your eligible dependents as a result of your marriage
- Your divorce, legal separation or annulment — If you become divorced or legally separated, or your marriage is annulled, you must cancel your Spouse from coverage since he or she is no longer an eligible dependent. You may be required to provide legal evidence of the event. You also may remove dependent children from coverage, if necessary, if you become divorced or legally separated, or your marriage is annulled. Coverage will end on the date of the divorce, legal separation or annulment. If you do not call 877 633 9837 within 60 days after the divorce, legal separation or annulment, you may not receive a refund of the premiums paid on your dependent's behalf. In addition, you will be responsible for repaying the Plan for any benefits that are paid on behalf of any ineligible dependents. Your newly ineligible dependents will not be able to enroll in COBRA or continuation coverage.
- The birth, adoption or placement for adoption of your child
- You become a legal guardian or obtain legal custody of a child
- A change in your (or your Spouse's or Domestic Partner's) eligibility that causes a loss or gain of benefits
- Coverage under your Spouse's or Domestic Partner's plan stops or begins because your Spouse or Domestic Partner changes elections during his/her Annual Enrollment
- A change in your dependent's eligibility that causes a loss or gain of benefits
- You or your dependent involuntarily lose coverage under another employer's plan
- Your (or your dependent's) loss of eligibility for COBRA or continuation coverage through another non-Sodexo medical plan for any reason
- Your (or your dependent's) eligibility for Medicare or Medicaid
- You or your eligible dependents lose Medicaid or state sponsored Children's Health Insurance Program (CHIP) coverage because you are no longer eligible (you must enroll your eligible dependent within 60 days of loss of coverage)
- You or your eligible dependents become eligible for a state's premium assistance program under Medicaid or CHIP (you must enroll your dependents within 60 days of becoming eligible for a state program)
- A change in your requirement to cover your dependent according to a Qualified Medical Child Support Order (QMCSO)
- Your death or an eligible dependent's death
- You establish a new Domestic Partnership—Affidavit required

You may be asked to provide documentation when you enroll in the Plan or cancel coverage for yourself or your dependent under any of these circumstances.

CANCELING YOUR COVERAGE

Because contributions for the PPO Option are made on a Before-Tax basis, coverage may only be canceled during Annual Enrollment or within 60 days of a qualifying event. However, coverage for Domestic Partners and their children may be canceled at any time since contributions are on an After-Tax basis.

WHEN YOUR COVERAGE ENDS

Your and/or your dependent's coverage under the Plan ends on the earliest of the following:

- The last day of an authorized Leave of Absence if you have not returned to work, or on the day you notify your manager that you will not return to work, whichever is earlier
- The Friday coinciding with or following your request to cancel coverage because of a qualifying event
- The day your active employment ends (vacation or severance do *not* automatically extend employment). You may continue PPO Option coverage for yourself and your covered dependents under COBRA or continuation coverage. See the *Continued Coverage* section on page 46
- The day you or your covered dependents are no longer eligible for the Plan. You may continue coverage for yourself and your dependents under COBRA or continuation coverage. See the *Continued Coverage* section on page 46
- The last week-ending date for which your coverage is paid
- The day the Plan is terminated
- Upon receipt of the Domestic Partner Cancellation Form. When the Domestic Partner Cancellation Form is received prior to the date of the actual termination of the relationship, the effective date will be the date of the termination. If the Domestic Partner Cancellation Form is received after the actual date of the relationship termination, the effective date will be processed retroactively to the actual date of the termination. Note: Imputed income will be adjusted accordingly
- The day of your death. Your covered dependents may continue PPO Option coverage under COBRA or continuation coverage. If your covered dependents elect COBRA or continuation coverage, the first 60 days will be at no cost. See the *Continued Coverage* section on page 46
- For your Spouse, on the day you legally separate or divorce or your marriage is annulled (a copy of the divorce decree or documents establishing the separation or annulment will be required to cancel your Spouse's coverage)
- The date determined by the Plan Administrator, if you (or your covered dependent) commit a fraudulent act for purposes of obtaining coverage or filing claims, or allow someone else to use your coverage
- The day you retire. You may continue coverage for yourself and your covered dependents under COBRA or continuation coverage. See the *Continued Coverage* section on page 46
- Ineligibility to Participate — If for any reason other than those stated above, you become ineligible to participate in the Plan, your coverage ends on the date that you no longer meet the eligibility requirements previously described; this applies to your dependents as well.

When your coverage ends for any reason, your dependent's coverage ends automatically.

Domestic Partner Status

If there is any change in your Domestic Partner status; for example, a change in the joint residence or shared financial responsibility that would make your Domestic Partner ineligible for coverage, you must submit a Domestic Partner Cancellation Form. If you do not call 877 633 9837 to cancel coverage when your Domestic Partner or Domestic Partner's child become ineligible, you will be responsible for repaying the Plan for any benefits that were paid on behalf of your ineligible Domestic Partner after the Domestic Partner becomes ineligible. Also, if you do not contact 877 633 9837 or cancel coverage within 60 days of when your Domestic Partner or Domestic Partner's child becomes ineligible, they will not be able to enroll in continuation coverage.

The following events may affect your child's eligibility:

- **Your covered child turns age 26** — When your child turns 26, he/she is no longer an eligible dependent on your coverage. Coverage ends on your child's 26th birthday. However, your child may continue PPO Option coverage under COBRA or continuation coverage. See the *Continued Coverage* section on page 46.
- **Your covered child is disabled and turns age 26** — You may be able to continue your child's coverage. Call 877 633 9837 before your child's 26th birthday and provide information regarding your child's disability. To be considered, your child must have been enrolled in the PPO Option on the day before reaching age 26. Coverage will continue without any break if the Plan Administrator determines that your child is eligible for Plan participation as a disabled dependent. To remain eligible for coverage as a disabled dependent, your child must maintain continuous coverage. Periodically, you may be asked to provide proof of your child's condition.

FRAUDULENT ACT

If you commit a fraudulent act, the Plan Administrator may cancel all or some Company-sponsored plan coverage(s) for you and your covered dependents on the date specified by the Plan Administrator in a written notice. If this occurs, you and your covered dependents may be ineligible to participate in any Company-sponsored plans at a later date. In addition, civil and/or criminal penalties can result from these acts.

OPTION TO CONTINUE COVERAGE

If you leave the Company or retire, you and your dependents may be able to continue your PPO Option coverage under certain circumstances. See the *Continued Coverage* section on page 46.

COVERAGE FOR YOUR DEPENDENTS IF YOU DIE

If you die, your covered dependents may elect to continue coverage. The first 60 days of coverage is free to your dependents if they choose coverage within the applicable election period. However, the free 60-day period will count toward the 18, 29 or 36 months of coverage. After the 60th day, your dependents must pay the required premium payments to continue coverage. The free 60-day coverage period is not automatic. Your dependent must actively elect to continue coverage to receive the free 60-period of coverage.

HOW THE PLAN WORKS

The PPO Option under the Sodexo Medical Plan is a Preferred Provider Organization (PPO) that offers you a choice of In-Network or Out-of-Network care. The Plan's claims administrator is Cigna. In-Network benefits are provided when you use Providers that participate in Cigna's nationwide Network used with Cigna's Open Access Plus/CareLink product.

To receive benefits under the PPO Option, you and your dependents may be required to pay a portion of the Covered Expenses for services and supplies. The portion you pay is called the Copay, Deductible or Coinsurance.

If you have any questions about your coverage or claims, call Cigna at 800 909 2227.

IN-NETWORK VS. OUT-OF-NETWORK CARE

Each time you or your family members need medical care, you decide if you want to use In-Network or Out-of-Network Providers. Network Providers are screened by Cigna for education, experience, credentials and commitment to managing overall patient care. In-Network Providers have agreed to provide their services at a Contracted Rate and your Out-of-Pocket expenses are typically lower. The chart on page 18 shows you the differences in benefits and features when care is received In- and Out-of-Network.

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 Cigna at 800 909 2227 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.

FINDING A NETWORK PROVIDER

To find a Provider in the Network, visit www.myCigna.com and use the Provider directory or call Cigna at 800 909 2227, 24 hours a day, seven days a week.

Choice of Primary Care Physician

Cigna does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician to receive all benefits available to you under this Plan. However, a Primary Care Physician serves 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.

For information on how to select a primary care Provider, and for a list of the participating primary care Providers, visit www.myCigna.com or call Cigna at 800 909 2227.

Changing Primary Care Physicians

You can change from one Primary Care Physician to another at any time. Visit www.myCigna.com or call Cigna at 800 909 2227. If at any time your designated 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.

YOUR COSTS

Your Out-of-Pocket costs depend on whether you use In-Network or Out-of-Network Providers. Your costs may include:

- Copays
- Coinsurance
- Copays plus Coinsurance
- Plan Year Deductible
- Any expenses above the Maximum Reimbursable Charge for Out-of-Network services, also called Balance Billing

Coinsurance

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

Contracted Rate

The Contracted Rate is the dollar amount Cigna has contracted with its In-Network Providers for the services they render. For example: An In-Network doctor bills Cigna $100 for an office visit and the Contracted Rate for this type of service is $80. The customer is liable for the $20 Copay and Cigna reimburses the Provider $60. The remaining $20 is absorbed by the Provider.

Copays/Deductibles

Copays are expenses to be paid by you or your dependent for covered services. Deductibles are also expenses to be paid by you or your dependent. A Deductible is the amount you need to pay in covered health expenses before the Plan begins paying a percentage of your costs. Deductible amounts are separate from and not reduced by Copays. Copays and Deductibles are in addition to any Coinsurance. Once the Deductible maximum has been reached, you and your family need not satisfy any further medical Deductible for the rest of that year.

Maximum Reimbursable Charge

The Maximum Reimbursable Charge applies to Out-of-Network claims. The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the Provider's normal charge for a similar service or supply; or
- a 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.

Out-of-Network claims are reimbursed based on the Maximum Reimbursable Charge. Any charges submitted by an Out-of-Network Provider in excess of the Maximum Reimbursable Charge may be billed to the customer, also called Balance Billing.

Balance Billing

Balance Billing applies to Out-of-Network Providers and facilities. Because they do not directly contract with Cigna, they do not agree to honor Cigna's discounts on services. This allows Out-of-Network Providers to bill the customer for the difference between what Cigna pays them and what they charge for their services.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the benefit Plan because of any amounts owed for the Deductible or Coinsurance that you are required to pay.

Out-of-Pocket Maximum

To protect you and your family from the cost of a catastrophic illness or accident, the Plan has an Out-of-Pocket Maximum. This means the amount you pay each Plan Year for covered medical expenses is limited. Once you reach the Out-of-Pocket Maximum, the Plan will pay 100% of most covered services for you for the remainder of the Plan Year. Certain expenses do **not** count toward the Out-of-Pocket Maximum including charges for:

- Office visit Copays
- Your pay deductions
- The $75 emergency room Copay
- The $20 Urgent Care services Copay
- Expenses over the Maximum Reimbursable Charge
- Any penalties for not adhering to Prior Authorization requirements (if applicable)
- Prescription drug Copays or Coinsurance
- Any non-covered services

Once you reach the Out-of-Pocket Maximum, you are still responsible for paying the items listed above. The Plan Year Deductible will count toward meeting the Out-of-Pocket Maximum.

Estimating the Cost of Care

Cigna provides tools to estimate the cost of care at its website www.myCigna.com. If you have any questions about your costs of care, call Cigna at 800 909 2227.

PPO Option Feature	In-Network	Out-of-Network
Choice of Providers	Each time you need medical care, you make an appointment with a Participating Provider.	Each time you need medical care, you may use any doctor you choose.
Coverage Level	The Plan pays 70% of the cost after you meet the Plan Year Deductible, or 100% after the Copay depending on the service being provided.	The Plan pays 60% of the Maximum Reimbursable Charge after you meet the Plan Year Deductible.
Claims	The In-Network doctor files the claim for you.	You may need to file your own claim for reimbursement.

THE PPO OPTION BENEFITS		
	In-Network Benefits	**Out-of-Network Benefits**
Plan Year Deductible Individual Family	 $500 $1,500	 $1,000 $3,000
Plan Year Out-of-Pocket Maximum (per person)	$5,000	$10,000
Lifetime Maximum	No Lifetime Maximum	
Preventive Care (includes routine physicals, well-baby care, gynecological exams, immunizations, etc.)	Covered at 100% not subject to Copay, Deductible, Coinsurance or Out-of-Pocket Maximum	Covered at 100% not subject to Copay, Deductible, Coinsurance or Out-of-Pocket Maximum Balance Billing may apply
Office Visits	You pay a $20 Copay per visit, the Plan pays 100%	You pay 40%, and the Plan pays 60% of the Maximum Reimbursable Charge
Coinsurance	You pay 30%, and the Plan pays 70% after Deductible.	You pay 40%, and the Plan pays 60% of the Maximum Reimbursable Charge after Deductible

Deductibles and Maximums

The In-Network Plan Year Deductible and Out-of-Pocket Maximum will be applied toward the Out-of-Network Deductible and Out-of-Pocket Maximum. However, the Out-of-Network Plan Year Deductible and Out-of-Pocket Maximum will not be applied toward the In-Network Deductible and Out-of-Pocket Maximum.

Example

Suppose you receive In-Network benefits under the PPO Option and reach your $500 In-Network Deductible. If you then go Out-of-Network for treatment, the $500 will be applied to the $1,000 Out-of-Network Deductible. That means you would have to pay an additional $500 to reach the Out-of-Network Deductible.

However, you would not be able to apply any amounts paid toward the Out-of-Network Deductible to the In-Network Deductible. That means that if you reach your $1,000 Out-of-Network Deductible and then receive care within the Network, you would have to pay the entire $500 In-Network Deductible before benefits would be paid.

PRIOR AUTHORIZATION (IN-NETWORK)

Prior Authorization helps you and your covered dependents obtain the most appropriate, effective and cost-efficient care. Cigna's staff will review the planned level of care within a reasonable time of receiving necessary medical records or requested information.

When you use an In-Network Provider or facility it is the responsibility of the Provider to obtain Prior Authorization for your treatment for services that require it, see Services Requiring Prior Authorization on page 18. As it is not your responsibility to request Prior Authorization, any penalties for not obtaining proper Prior Authorization will not apply to you when you use an In-Network Provider.

Prior Authorization (Out-Of-Network)

When you use an Out-of-Network Provider or facility, it is your responsibility to obtain Prior Authorization for your treatment in situations that require it by calling Cigna at 800 909 2227. Out-of-Network Providers generally do not provide this service for patients. Covered Expenses under the Plan will be reduced or denied (before the Deductible and Coinsurance amounts are calculated) if you do not obtain Prior Authorization for your treatment.

Services Requiring Prior Authorization

The following is a list of services requiring Prior Authorization. Keep in mind, this is not a complete list. If you have questions about specific services, call Cigna at 800 909 2227 so as not to incur a claim denial and any unnecessary Out-of-Pocket expenses.

- inpatient Hospital services
- inpatient services at any participating Other Health Care Facility such as a Skilled Nursing Facility (see Glossary on page 68 for definition of Other Health Care Facility)
- residential treatment
- outpatient facility services
- advanced radiological imaging
- transplant services

Required Information

When you call Cigna at 800 909 2227 to obtain Prior Authorization of your care, you will need to provide all of the following information:

- The group plan number on your medical ID card
- The covered employee's Social Security number
- The name of the covered person receiving the treatment
- The medical information concerning the treatment, admission or surgery
- The doctor's name, address and phone number
- The name of the Hospital or facility providing the treatment

The following chart shows the amount of the reduction for not obtaining Prior Authorization for your Out-of-Network care.

If You Do Not obtain Prior Authorization for Out-of-Network Care…	The Penalty Is …
Before any scheduled non-emergency admission (including mental health or Substance Abuse admission) to a Hospital, non-Hospital residential facility or intermediate care facility	$500
Within two days after an emergency or unscheduled admission (including mental health or Substance Abuse admission) to a Hospital, non-Hospital residential facility or intermediate care facility	$500
Before any bone marrow or organ transplant	$500
Before receiving home health, private duty nursing or Skilled Nursing Facility care	$500

The penalty will not apply toward the Out-of-Pocket Maximum or the Plan Year Deductible. If an unplanned admission occurs after business hours or on a weekend or holiday, call Cigna at 800 909 2227 within 48 hours following the admission.

INPATIENT CERTIFICATION REQUIREMENTS (OUT-OF-NETWORK)

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) are the processes used to certify the Medical Necessity and length of a Hospital Stay when you or your dependent require treatment in a Hospital:

- as a registered bed patient;
- for a partial hospitalization for the treatment of mental health or Substance Abuse;
- for mental health or Substance Abuse residential treatment services.

You or your dependent should request Pre-Admission Certification prior to any non-emergency treatment in a Hospital. In the case of an emergency admission, you should contact Cigna within 48 hours after the admission. For an admission due to pregnancy, you should call Cigna by the end of the third month of pregnancy. If you require a stay beyond the original limit certified by your Pre-Admission Certification, you should request Continued Stay Review prior to the end of your certified length of stay, in order to continue coverage for a Hospital Stay.

If Pre-Admission Certification is not received for each separate admission to the Hospital, a $500 penalty will be charged and will be removed from the amount paid for Covered Expenses. This also applies to emergency admissions that are not certified within 48 hours of the date of the admission. Benefits will not be paid for:

- Hospital charges for any days in excess of the number of days certified through Pre-Admission Certification or Continued Stay Review; and
- Hospital charges for which Pre-Admission Certification was requested, but was not certified as Medically Necessary.

Pre-Admission Certification and Continued Stay Review are performed through a utilization review program through Cigna.

OUTPATIENT CERTIFICATION REQUIREMENTS (OUT-OF-NETWORK)

Outpatient certification is 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 Cigna at 800 909 2227 to determine if outpatient certification is required prior to any outpatient diagnostic testing or procedures. Outpatient certification is performed through a utilization review program through Cigna. Outpatient certification should only be requested for nonemergency procedures or services, and should be requested at least four business days (Monday through Friday) prior to having the procedure performed or the service rendered.

If outpatient certification is not received prior to the date of the diagnostic testing or procedure is performed, a $500 penalty will be charged and will be removed from the amount paid for Covered Expenses. Benefits will not be paid for charges made for outpatient diagnostic testing or procedures for which outpatient certification was requested but was not certified as Medically Necessary.

DIAGNOSTIC TESTING AND OUTPATIENT PROCEDURES

Including, but not limited to:

- Outpatient surgery
- High-tech radiology (MRI, CAT Scans, PET Scans)
- Injectible drugs (other than self-injectibles)
- Durable medical equipment (insulin pumps, specialty wheelchairs, etc.)
- Home health care/home infusion therapy
- Dialysis (to direct to a participating facility)
- External Prosthetic Appliances
- Biofeedback
- Speech therapy
- Reconstructive procedures

PREVENTIVE CARE

The PPO Option focuses on keeping you well, rather than just providing coverage for covered illness or Injury. The Plan includes coverage for preventive care services for men, women and children and complies with the Patient Protection and Affordable Care Act.

The PPO Option covers the following In-Network and Out-of-Network preventive care at 100%. The preventive care described below is not subject to Copay, Deductible or Coinsurance for both In- and Out-of-Network Providers. Out-of-Network preventive care may be subject to Balance Billing. Your doctor will determine the tests and frequency that are right for you based on your age, gender and family history.

Other services provided at the time of your well visit or checkup that are not listed as preventive will be considered under your standard medical coverage. This means you may be responsible for paying a share (Copay or Coinsurance) of the cost for those services. Please note that the preventive health care services, screenings, tests and vaccines listed are not recommended for everyone. You and your health care Provider should decide what care is most appropriate.

Preventive Care - Children – Birth Through 18 Years

Preventive care physical exams are covered, as well as the screenings, tests, counseling and vaccines listed below:

Screenings, Tests and Counseling	Vaccines
Vision screening	Hepatitis A
Hearing screening	Hepatitis B
Oral health screening/Dental caries prevention	Diphtheria, tetanus, Pertussis (DtaP)
Screening for lead exposure	Varicella (chicken pox)
Anemia screening	Influenza (flu)
Tuberculosis screening	Pneumococcal conjugate (pneumonia)
Pelvic exam and Pap test	Human papillomavirus (HPV)
Newborn screenings	Haemophilus influenzae type b (Hib)
Development and behavior tests	Polio
Cholesterol and lipid level screening	Measles, mumps, rubella (MMR)
Screening for depression	Meningococcal polysaccharide
Obesity screening and counseling	Rotavirus
Autism screening	
Blood pressure	
Behavioral counseling to promote a healthy diet	
Screening for sexually transmitted infections	

Preventive Care - Adults – 19 Years and Older

Preventive care physical exams are covered, as well as the screenings, tests, counseling and vaccines listed here.

Screenings, tests and counseling	Vaccines
Vision eye chart test	Hepatitis A
Hearing screening	Hepatitis B
Cholesterol and lipid level screening	Diphtheria, tetanus, Pertussis (DtaP)
Diabetes screening	Varicella (chicken pox)
Prostate cancer screening including digital rectal exam and PSA test	Influenza (flu)
Breast exam, breast cancer screening and mammography	Pneumococcal conjugate (pneumonia)
Pelvic exam and Pap test	Human papillomavirus (HPV)
Screening for sexually transmitted infections	Measles, mumps, rubella (MMR)
Screening for HIV	Meningococcal polysaccharide
Bone density test to screen for osteoporosis	Herpes zoster (shingles)

Colorectal cancer screening including fecal occult blood test, barium enema, flexible sigmoidoscopy and screening colonoscopy	
Aortic aneurysm screening	
Pregnancy screenings including, but not limited to: • Hepatitis • Asymptomatic bacteriuria • Rh incompatibility • Syphilis • Iron deficiency anemia • Gonorrhea • Chlamydia Note: These services were previously covered under maternity benefits instead of preventive.	
Screening and intervention services (including counseling and education) for: • Obesity • Genetic testing for breast and ovarian cancer • Behavioral counseling to promote a healthy diet • Breastfeeding • Aspirin use for the prevention of cardiovascular disease • Tobacco use and diseases caused by tobacco use • Alcohol use	

For a list of preventive care medications covered under the PPO Option through the Medco Prescription Drug program, see the *Preventive Medications* section on page 30.

BENEFIT COVERAGE

The medical benefits provided under the PPO Option appear in alphabetical order on the following pages. Unless specifically stated otherwise, the following applies:

- The PPO Option covers most services at 70% after Deductible In-Network or 60% after Deductible Out-of-Network
- The Plan Year Deductible must be met before any benefits are paid.
- All Out-of-Network charges are subject to the Maximum Reimbursable Charge.

COVERED SERVICES

For expenses to be covered, they must be all of the following:

- Incurred while you are covered under the Plan
- Medically necessary
- Provided by a licensed Provider or facility

If you have questions about whether a specific service is covered, call Cigna at 800 909 2227. It's best to call and verify before services are rendered to avoid denial of claims.

Acupuncture

Acupuncture treatment is covered for up to 10 days per Plan Year when services are provided by any Provider working within the scope of their license.

Air Ambulance

Claims will be covered only if they are Medically Necessary. Call Cigna at 800 909 2227 for more information.

Allergy Testing and Treatment
Allergy testing services are performed to diagnose the cause of the allergies and determine the treatment necessary to manage them. These services and resulting treatments are covered at 100% after your Copay or the actual charge for treatment, whichever is less when you use In-Network Providers and at 60% after Deductible when Out-of-Network Providers are used. There is no charge In-Network for the allergy serum dispensed in the doctor's office. Allergy serum is covered at 60% after Deductible Out-of-Network.

Ambulance
The Plan covers local professional ambulance services at 70% after Deductible both In-Network and Out-of-Network:

- From the place of Injury or illness to the nearest facility equipped to provide immediate emergency medical treatment
- For transfers between Hospitals to obtain specialized diagnostic or treatment services while confined as an inpatient
- For transfers from an Out-of-Network facility to an In-Network facility

Other travel expenses, including transfers for the convenience of the patient or doctor, are not covered

Anesthesia
For benefit information, see *Surgical Expenses* on page 35.

Cancer Clinical Trials
Cancer Clinical Trials may be covered if charges are made for routine patient services associated with clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:

- the clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
- the trial investigates a treatment for terminal cancer and: the person has failed standard therapies for the disease; cannot tolerate standard therapies for the disease; or no effective nonexperimental treatment for the disease exists;
- the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol";
- the trial is approved by the Institutional Review Board of the institution administering the treatment; and
- coverage will not be extended to clinical trials conducted at nonparticipating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed herein as exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial Nurse.

Chiropractic Services
Chiropractic services include charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function. For these services, you have direct access to qualified chiropractic Physicians.

The following limitation applies to chiropractic services:

- Chiropractic services are covered In-Network at 100% after the office visit Copay and Out-of-Network at 60% after Deductible. There is a 30 day limit per Plan Year.

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Chiropractic services that are not covered include but are not limited to:
- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or Preventive Treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- vitamin therapy.

Dental-Related Services

Limited to charges made for a continuous course of dental treatment started within six months of an accidental Injury to sound, natural teeth. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

Non-Surgical Temporomandibular Joint Disorder - Non-Surgical treatment of TMJ includes coverage of appliances for alignment of the jaw, exams, X-rays, Splints and transcutaneous electro nerve stimulator (TENS).

Surgical Temporomandibular Joint Disorder - Surgical intervention may be considered when conservative, nonsurgical therapies are unsuccessful in treating patients with defined intra-articular disorders and a high degree of pain and dysfunction exists. The following surgical procedures may be used to treat TMJ:
- Arthrocentesis
- Arthroscopy
- Arthrotomy
- Prosthetic Joint Replacement

Physician office visits are covered at 100% In-Network after Deductible and office visit Copay and 60% Out-of-Network after Deductible. Dental care services in both an inpatient and outpatient facility and Physician's services are covered at 70% after Deductible In-Network and 60% after Deductible Out-of-Network.

Routine Testing

Routine X-rays and lab tests as part of preventive care visits are covered at:
- 100% when performed by an In- or Out-of-Network Provider (Balance Billing may occur Out-of-Network)

Non-Routine Testing (includes pre-admission testing)

Non-routine diagnostic testing refers to X-rays, ultrasounds, CAT scans and MRIs. The Plan covers Medically Necessary non-routine testing at:
- 100% after the office visit Copay if performed in an office setting.
- 70% after Deductible if performed outside of the doctor's office.
- 60% after Deductible if performed by an Out-of-Network Provider.

Durable Medical Equipment

Durable Medical Equipment must be prescribed and required for therapeutic use. In cases where Durable Medical Equipment is needed for long-term care, call Cigna at 800 909 2227 to determine if the purchase of the equipment is covered by the Plan. Durable Medical Equipment is covered at 70% after Deductible In-Network and 60% after Deductible Out-of-Network.

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, respirators, wheel chairs, and dialysis machines.

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. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician. Coverage does not include: bed related items; bath related items; chairs, lifts and standing devices; fixtures to property; car/van modifications; air quality items; and blood/injection related items.

Emergency Care

Emergency care is covered In- and Out-of-Network at 70% after Deductible and after a $75 Copay per visit. The Plan covers facility and professional Emergency Care services and supplies received in a Hospital emergency room or freestanding medical unit. Emergency care services include the initial treatment of traumatic bodily injuries resulting from an accident or treatment of a sudden medical emergency requiring immediate care.

The $75 emergency room Copay will be waived if you are admitted to the Hospital. You must call Cigna to obtain Prior Authorization of your care within 48 hours of the admission if you are admitted after an emergency. See the *Prior Authorization* section on page 18.

If an Out-of-Network facility is used in an emergency situation, the facility may Balance Bill you for costs incurred but not covered by the Plan. See page 17 for Balance Billing information.

External Prosthetic Appliances

Coverage for External Prosthetic Appliances includes the initial purchase and fitting of External Prosthetic Appliances and devices available only by prescription that are necessary for the alleviation or correction of Injury, Sickness or congenital defect.

External Prosthetic Appliances and devices shall include Prostheses/Prosthetic Appliances and Devices, Orthoses and Orthotic Devices; Braces; and Splints. Prostheses/Prosthetic Appliances and Devices are defined as fabricated replacements for missing body parts. Orthoses and Orthotic Devices are defined as Orthopedic Appliances or Apparatuses used to support, align, prevent or correct deformities. 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. A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts. Coverage for External Prosthetic Appliances is provided at 70% after Deductible In-Network and 60% after Deductible Out-of-Network.

Coverage for replacement of External Prosthetic Appliances and devices is limited to the following:

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

Coverage for replacement is limited as follows:

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

The following are specifically excluded External Prosthetic Appliances and devices:

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

Family Planning

Family Planning services are covered, including:

- medical history,
- physical exam,
- related laboratory tests,
- medical supervision in accordance with generally accepted medical practices,
- other medical services,
- information and counseling on contraception,
- medical services connected with surgical therapies (tubal ligations, vasectomies).

Office visits, laboratory and radiology tests and counseling related to family planning are covered at 100% after office visit Copay In-Network and 60% after Deductible Out-of-Network. All other family planning services are covered at 70% after Deductible In-Network and 60% after Deductible Out-of-Network.

Gender Affirmation Surgery

See *Surgical Expenses* on page 35.

Hearing Exams

See *Preventive Care* on page 21

Home Health Care

Covered home health care services include:

- Part-time or intermittent home nursing care provided or supervised by a Registered Nurse (R.N.)
- Part-time or intermittent home health aid services, primarily for the care of the patient
- Private Duty Nursing provided in the home

Services and supplies furnished by a Home Health Care Agency in a person's home are limited to 120 days per Plan Year. The Plan covers most services at 70% after Deductible In-Network and 60% after Deductible Out-of-Network. The maximum number of covered Home Health Care hours per day is limited to 16 hours. Multiple visits can occur in one day, with a visit defined as a period of 2 hours or less (e.g., maximum of 8 visits per day). To qualify for home health care benefits, you must be under the care of a doctor. Your doctor must submit a home health care plan for your care and treatment to Cigna for Prior Authorization before the start of your home health care. See *Prior Authorization* on page 18.

Hospice Care

Hospice services, supplies and bereavement counseling are covered for terminally ill patients with a life expectancy of 6 months or less as determined by a Physician. Expenses incurred by a terminally ill person are covered at 70% without the need to meet a Plan Year Deductible. Covered services by a Hospice Facility include all of the following:

- Bed, Board, Services and Supplies (inpatient)
- Services provided on an outpatient basis
- Services provided by a Physician for professional services
- Services provided by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- Pain relief treatment, including drugs, medicines and medical supplies;

Covered services by any other Health Care Facility include the following:

- Part-time or intermittent nursing care by or under the supervision of a Nurse;
- Part-time or intermittent services of a Provider;
- 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.

Hospital Care

Prior Authorization is required for inpatient care. See the *Prior Authorization section* on page 18.
The Plan covers semi-private room and board expenses at 70% after Deductible In-Network and 60% after Deductible Out-of-Network, including:

- Use of operating, delivery and treatment rooms
- Prescribed drugs
- Whole blood, administration of blood, blood processing and blood derivatives
- Anesthesia, supplies and the administration of anesthesia
- Medical and surgical dressings, supplies, casts and Splints
- Diagnostic services
- Therapy services
- A private room, intensive care, coronary care and other specialized treatments are covered when Medically Necessary

Pre-Admission Testing

The Plan covers In-Network pre-admission tests at:

- 100% after the office visit Copay if the tests are performed in the doctor's office.
- 70% after Deductible if the tests are performed outside of the doctor's office
- On an Out-of-Network basis, all pre-admission tests are covered at 60% after Deductible
- Charges for duplicate tests done at admission will not be covered unless they are Medically Necessary

Preventive Care

See *Preventive Care* section on page 21.

Laboratory Services

Laboratory services are covered at 100% after the office visit Copay in an office setting. Laboratory services rendered in a Hospital-affiliated laboratory or independent X-ray and/or Lab Facility will be subject to the Deductible and Coinsurance.

Maternity Care

After the initial office visit Copay for In-Network Providers, the Plan covers maternity care at 100% for the Physician's Global Maternity Fee which typically includes all normal prenatal visits, postnatal visits and Physician's delivery charge. Office visits in addition to the Global Maternity Fee are covered at 100% after the office visit Copay. In-Network Hospital expenses are paid at 70% after Deductible. On an Out-of-Network basis, all maternity care is covered at 60% after Deductible.

Covered Expenses for maternity care include all of the following:

- Alternative medical care, including birthing center charges and certified Nurse-midwife fees (Birthing centers must meet certain licensing requirements to be covered under the Plan. Call Cigna at 800 909 2227 for more information.)
- Circumcision, if completed during the initial Hospital stay.
- Doctor's office visits and/or lab tests to diagnose the pregnancy
- Hospital expenses including charges for room and board, labor room, recovery room, anesthesia supplies and services, drugs, oxygen, and other Medically Necessary services and supplies
- Medically necessary tests and X-rays
- Obstetrician fees during the pregnancy and for delivery and postnatal care

The Plan provides maternity benefits for a mother and newborn child for Hospital stays up to:

- 48 hours following a vaginal delivery
- 96 hours following a cesarean delivery

If you or a newborn child need a longer Hospital stay than those listed above, you or your doctor *must* call Cigna at 800 909 2227 for Prior Authorization (also applies to the newborn child) for all extra days required; otherwise, your Out-of-Network Covered Expenses (including room and board) for any days not authorized will not be covered.

Cigna offers a free prenatal care program for expectant mothers. See the *Healthy Pregnancies, Healthy Babies Program* section below. For detailed information on authorizing your maternity Hospital stay, see the *Prior Authorization* section on page 18.

Cigna Healthy Pregnancies, Healthy Babies® Program – Free Program for Expectant Mothers
While most women have a healthy, uncomplicated pregnancy, others may need specialized care to deliver a healthy baby. Through Healthy Pregnancies, Healthy Babies®, Cigna's comprehensive maternity support program, Cigna supports pregnant customers and customers considering pregnancy. The program includes preconception and prenatal education through print and online tools, incentives for participating, a comprehensive assessment of each Nurse and development of individualized care plans tailored to each customer's specific needs.

What's more—you can earn money just by participating in the program!
- If you enroll in your first trimester, Cigna will send you a check for $250 at the completion of the program.
- If you enroll in your second trimester, Cigna will send you a check for $125 at the completion of the program.

Enrollment is not automatic. This program is available to customers enrolled in the PPO Option. You must contact Cigna at 800 909 2227 to enroll in the program.

Mental Health

Mental Health – Prior Authorization
All inpatient mental health treatment must be properly authorized before admission. (See the *Prior Authorization* section on page 18.)

Mental Health - Inpatient
The Plan covers inpatient mental health at 70% after Deductible In-Network and 60% after Deductible Out-of-Network. Coverage for Out-of-Network inpatient mental health treatment will be based on the Hospital or facility's most common semi-private room rate

Mental Health - Outpatient
For In-Network outpatient mental health office visits, the Plan covers treatment at 100% after the office visit Copay. On an Out-of-Network basis, mental health treatment is covered at 60% after Deductible. For treatment in an Outpatient Facility, the Plan covers treatment at 70% after Deductible In-Network and at 60% after Deductible Out-of-Network.

Identical coverage is offered for Substance Abuse treatment. See Substance Abuse on page 35.

Nutritional Evaluation
Charges made for three visits for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease. The three visit limit does not apply to nutritional counseling for diabetes.

Prescription Drugs

Medco, the Prescription Benefits Manager for the PPO Option, has an extensive Network of participating pharmacies that offer discounted prices for your eligible prescription drugs. If you purchase prescription drugs from a non-Network pharmacy, you will have to pay the full cost. The Plan does not cover prescriptions filled at Out-of-Network pharmacies.

Coverage is limited to prescription drugs and prescription medicines approved by the United States Food and Drug Administration, which by law can be dispensed only by prescription and only by a licensed pharmacist. Drugs prescribed by a licensed Physician outside the U.S. will not be covered if they are not approved by the U.S. Food and Drug Administration.

The Medco Prescription Benefit Plan covers prescription drugs that are:

- Medically necessary for the care and treatment of an illness or Injury
- Prescribed in writing by a Provider who is licensed to prescribe federal legend prescription drugs or medicines
- Not listed under the *Prescription Drug Exclusions and Limitations* section

The Medco Prescription Benefit Plan also covers:

- Compounded medications of which at least one ingredient is a legend drug
- Smoking cessation drugs that help people stop smoking cigarettes or using other forms of tobacco
- Insulin, insulin needles and syringes
- Over the counter diabetic supplies
- Blood glucose monitors/meters
- Contraceptives – oral, transdermal and intravaginal
- Contraceptive injections (i.e. Lunelle and Depo Provera)
- Legend contraceptive devices
- MS therapy (i.e. Betaseron, Avonex, Copaxone and Rebif)
- Injectables (unless listed under exclusions)
- Retin-A/Avita (cream only) through age 35

For a list of drugs not covered by the prescription drug program, see *Exclusions* on page 41.

For prescription drug information visit www.medco.com or call Medco at 800 903 7968.

What Is a Formulary?

To remain cost effective for Participants, the PPO Option offers a lower Copay for only those drugs on a special list called a formulary. For more information about which drugs are listed on the prescription formulary, call Medco at 800 903 7968.

You must use a Network pharmacy to receive prescription drug benefits at the following Copay levels:

	Retail (for 30 day supply)			Mail Order (for 90 day supply)		
	Copay or Coinsurance	**Minimum**	**Maximum**	**Copay or Coinsurance**	**Minimum**	**Maximum**
Generic	$10	N/A	N/A	$20	N/A	N/A
Brand Name	10%	$35	$100	10%	$87.50	$200
Non-Formulary Brand Name	30%	$50	$150	30%	$125	$300
Preventive*	$0	N/A	N/A	N/A	N/A	N/A

Note: Non-sedating antihistamines such as Zyrtec and Clarinex are considered non-formulary.

**You must have an authorized prescription for the preventive medication to be covered at $0 Coinsurance.*

If you purchase prescription drugs from a non-Network pharmacy, you will have to pay the full cost. The Plan does not cover prescriptions filled at Out-of-Network pharmacies.

Prescription Drugs - Preventive Medications

The Plan covers the following preventive medications – both prescription and over-the-counter (OTC) – at a $0 Coinsurance. To receive these medications at a $0 Coinsurance, you must have an authorized prescription for the product (even for products sold over the counter (OTC)) and it must be dispensed by a participating mail or retail pharmacy.

- Aspirin – An OTC product for men age 45 to 79 and women age 55 to 79 for cardiovascular protection
- Folic Acid – OTC doses of 400 to 800 mcg/day for women who are pregnant or who are planning to become pregnant
- Fluoride – a prescription product for children to prevent dental cavities
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Any charge related to the administration of a vaccine in a doctor's office is covered under the terms of the PPO Option. See the Preventive Care section on page 21 for more details on covered vaccines.

• Anthrax	• Pertussis
• BCG	• Pneumococcal Conjugate (PCV)
• DTaP	• Pneumococcal Polysaccharide (PPSV)
• Hepatitis A	• Polio
• Hepatitis B	• Rabies
• Hib	• Rotavirus
• Hib and DTP	• Smallpox (Vaccina)
• HPV	• Tdap (adolescents) and Tdap (adults)
• Influenza	• Tdap and Td Vaccines and Pregnancy
• Japanese Encephalitis	• Typhoid
• Measles, Mumps and Rubella	• Varicella (Chickenpox)
• MMRV	• Yellow Fever
• Meningococcal	

- Iron supplements – an OTC product to treat/prevent anemia
- Smoking cessation products – some OTC and some prescription products
  - Nicotrol NS
  - Nicotrol Inhaler
  - Zyban
  - Chantix
  - Nicorette gum/Lozenge
  - Nicotine Transdermal System

Prescription Drugs - Mandatory Generics

Your prescription drug plan includes a mandatory generics program. This means that if the Brand Name Drug prescribed by your doctor has a generic equivalent, it will be substituted automatically with the generic version. If you still choose the Brand Name Drug, you will pay the generic Copay plus the difference in cost between the Generic Drug and the Brand Name Drug.

Prescription Drugs - Generics RxAdvantage Program (GRxA)

Generics Rx Advantage eliminates co-payments on any new generic that can be ordered from the **Medco Pharmacy™**. It also provides discounts that help customers to save all year long. Provides savings and discounts including:

- $*0 payment for your first 90-day supply*
- $25 discounts on select brand-name drugs that will soon have generic versions
- free standard delivery
- automatic refills upon request
- 24/7 access to pharmacists to answer questions

Customers must sign up on-line at www.medco.com or by phone by calling Medco at 800 633 2662.

Prescription Drugs - Mail Order

Retail Refill Allowance (RRA)

Very important: If you do not use Medco by Mail for mail order prescriptions on your Long-Term Medications and you instead use a retail pharmacy, you will be allowed the initial prescription and only two refills per drug under the Plan – this is known as the Retail Refill Allowance (RRA). **After the two refill maximum, if you want to refill your prescription at a retail pharmacy, you will have to pay 100% of the cost of the medication. Once you have reached the RRA, your Long-Term Medication will not be covered by the Plan if filled at a retail pharmacy.** You will be notified prior to your final refill of the need to move your prescription to mail order.

Medco by Mail

Using Medco By Mail can help you save money on your prescription drugs, with free shipping, 24/7 access to pharmacists, and safety checks for drug interactions. Medco offers a home delivery feature, which helps you control your costs on Long-term Medications. Medco home delivery allows you to get up to a 90-day supply with each refill (some medications due to certain state and federal laws cannot be dispensed in a 90-day supply), limiting your Copays and/or Coinsurance. (See the table on page 29 for Copay levels when you use the home delivery feature.)

The mandatory generics program applies to Medco By Mail. To order prescriptions using Medco By Mail, call 800 633 2662 or log on to www.medco.com.

Prescription Drugs - Medco Extended Payment Plan

Medco offers extended payments to assist with the cost of your mail-order prescriptions so they are more affordable. You can spread your prescription payments over three credit or debit card installments, so you don't have to pay the costs all at once. There's no waiting—your medication will be shipped after the very first payment.

When you're enrolled in the Extended Payment Plan (EPP), it will apply to every mail-order prescription for you and your eligible dependents. Below is an example of how EPP can make your prescriptions more affordable.

Member cost for medication	$90.00
Service fee (5% APR)	$ .38
Total	**$90.38**
How it's divided:	
Payment 1	$30.00
Paid at time of order; all medication shipped at this time	
Payment 2	$30.25
Paid in 30 days and includes portion of service fee	
Payment 3	$30.13
Paid in 60 days and includes remainder of service fee	
Total of 3 payments	$90.38

To get started with EPP, call Medco at 800 903 7968 or enroll online at www.medco.com.

If you do not have a credit or debit card, you can call Medco to request to pay by check or money order. This option is only available to you if the total cost of your medication is $100 or less. If it is $100 or less, Medco will send you a 90-day supply of your prescription and bill you. You will be responsible for paying the invoice by check or money order. Please note that the Medco mail order pharmacy will not provide a new supply of your medication or any new prescription until you have paid your account balance in full.

If you find that these payment options will not work for you and that the cost of the 90-day supply of your medication(s) through the mail order pharmacy would be a hardship, you may submit a written appeal to: Sodexo, ATTN: Benefits Operations, 9801 Washingtonian Blvd., Suite 119, Gaithersburg, MD 20878 or fax your appeal to Benefit Operations at 301 987 4161.

Prescription Drugs - Coordination of Benefits

The prescription drug plan does not have a Coordination of Benefits provision meaning you will not be reimbursed for your Out-of-Pocket costs for medications purchased through other insurance that is considered primary.

Prescription Drugs - Prescription Drug Coverage Limitations

The prescription drug benefit under the PPO Option has exclusions and coverage limits or preauthorizations on certain drugs. For example, prescription drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period.

If you submit a prescription for a drug that is not covered or has coverage limits, your pharmacist will tell you that you owe the full cost of the drug or approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use Medco by Mail®, your doctor will be contacted directly.

When the coverage limit is triggered, more information is needed to determine whether your use of the medication meets your Plan's coverage conditions. The Plan will notify you and your doctor of the decision in writing. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

Prescription Drugs – PPO Option Lifetime Maximum

There is no lifetime or annual maximum on benefits paid under the prescription drug coverage of the PPO Option.

Prescription Drugs - Prescription Drug Card

Your Medco identification card acts as your prescription drug card. Your Cigna identification card cannot be used for prescription coverage. Use your Medco ID card when purchasing prescriptions at participating pharmacies. If you are a new Plan Participant and you purchase prescription drugs before you receive your ID card, you will have to submit your receipt to Medco for reimbursement. For more information, call Medco at 800 903 7968.

You can print a temporary ID card from the Medco website once your coverage has become effective. Log on to www.medco.com and register. Choose Forms & Cards on the left of the screen. From there you can choose to print a temporary prescription card.

Most major pharmacies participate in the Network. If your pharmacy is not listed in the materials sent to you by the Plan, ask your pharmacist whether they participate in the Network. If your pharmacy is not in the Network and you would like it to be added, call Medco at 800 903 7968 or log on to www.medco.com.

My RXChoices — Take Control of Your Prescription Expenses

The My RXChoices tool allows you to compare costs for medications that you or your family are currently taking (or may need in the future) to lower-cost generic equivalents, Over-the-Counter (OTC) options, mail order pharmacy (Medco By Mail), and preferred brands. Knowing and understanding the alternatives available can result in substantial savings for you.

To encourage you and your Physician to discuss lower-cost alternatives, you can print a copy of the medication options, complete with pricing information to take with you to discuss with your Physician. Access the tool at www.medco.com. Logon using your e-mail and password. First time users must register. Once logged on, choose My RXChoices from the left margin.

Prescription Drugs - Emergency Situations

You may not have access to a participating pharmacy in an emergency. Medco has a number of procedures in place to assist customers in the event of an emergency or disaster situation. Should you require assistance in obtaining your medications and your pharmacy is unable to assist, please contact Medco by calling 800 903 7968**.**

Private Duty Nursing Care

See Home Health Care on page 26.

Short-Term Rehabilitative Therapy

The Plan covers In-Network therapy services at 100% after the office visit Copay. Out-of-Network therapy services are covered at 60% after Deductible.

Short-term Rehabilitative Therapy is therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limits apply to Short-term Rehabilitative Therapy:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness. Short-term Rehabilitative Therapy services that are not covered include but are not limited to:
- Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- Maintenance or Preventive Treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.

Multiple outpatient services provided on the same day constitute one day. A separate Copayment will apply to the services provided by each Provider.

The following limits apply to therapy services:

- For occupational, physical and speech therapy, up to 30 days each per Plan Year
- For pulmonary and cardiac rehabilitation, up to 60 days each per Plan Year
- Cognitive therapy is unlimited.

Therapy Services - Occupational Therapy

- Occupational therapy is provided only for purpose of enabling people to perform the activities of daily living after an Illness or Injury or Sickness.

Therapy Services - Physical Therapy
The Plan covers physical therapy services when ordered by a doctor for treatment of an accident, illness or surgery up to 30 days per Plan Year.

Therapy Services - Speech Therapy
Speech therapy services are covered when performed by a speech-language pathologist acting within the scope of his or her license. Coverage is provided for therapy to restore any speech loss or impairment resulting from an Injury, an illness, surgery for an illness or Injury, and a congenital defect up to 30 days per Plan Year. In addition, coverage is provided for therapy to restore oral-pharyngeal function. Speech education is not covered by the Plan.

Skilled Nursing Facility
You must properly authorize any admission to a Skilled Nursing Facility. See the *Prior Authorization* section on page 18. Benefits will be provided at a Skilled Nursing Facility at 70% after Deductible In-Network and 60% after Deductible Out-of-Network if all of the following criteria are met:

- The patient's needs require:
  - 24-hour per day access to a registered Nurse with specialized training in rehabilitation care;
  - frequent rehabilitation team assessment and intervention due to the potential risk of significant change in physical or medical status; and
  - The rehabilitation services require such an intensity, frequency and duration as to make it impractical for the individual to receive services in a less intense care setting
- The rehabilitative treatment plan includes at least two therapies (e.g., physical therapy, occupational therapy, speech therapy).
- The patient is stable enough medically and is capable and willing to participate in intensive therapy for a minimum of three hours per day, at least five days per week.
- The rehabilitation program is expected to result in significant therapeutic improvement over a clearly defined period of time.
- The rehabilitation program is individualized, and documentation outlines quantifiable, attainable treatment goals.
- Supervision is provided by a Physician with specialized training or experience in rehabilitation, including face-to-face visits at least three days per week to assess the individual both medically and functionally and make appropriate modifications to the course of treatment based upon the individual's medical condition and progress.

Covered Expenses include room and board and other services and supplies provided by the facility for medical care, such as drugs, dressings and therapy, if Medically Necessary. The maximum expenses for room and board are the facility's regular daily charge for a semi-private room.

60-Day Limit
Covered Expenses are limited to no more than 60 days of a Hospital Stay due to the same or related condition. Any new admission to a Skilled Nursing Facility will be considered an extension of the original stay, unless the new Hospital Stay begins after a complete recovery from the condition that caused any previous Hospital Stay, or is separated from a previous Hospital Stay by the covered employee's return to active work.

Speech Therapy
See *Therapy Services* on page 33.

Substance Abuse Treatment

Substance Abuse – Prior Authorization
All inpatient Substance Abuse treatment, must be properly authorized before the first visit. (See the *Prior Authorization* section on page 18.)

Substance Abuse Treatment - Inpatient

The Plan covers inpatient Substance Abuse treatment at 70% after Deductible In-Network and 60% after Deductible Out-of-Network. Coverage for Out-of-Network inpatient Substance Abuse treatment will be based on the Hospital or facility's most common semi-private room rate.

Substance Abuse Treatment - Outpatient

For In-Network outpatient Substance Abuse office visits, the Plan covers treatment at 100% after the office visit Copay. On an Out-of-Network basis, Substance Abuse treatment is covered at 60% after Deductible.

For treatment in an Outpatient Facility, the Plan covers treatment at 70% after Deductible In-Network and 60% after Deductible Out-of-Network.

Identical coverage is offered for Mental Health treatment. See Mental Health on page 28.

Surgical Expenses

Surgical expenses are covered at 70% after Deductible In-Network and 60% after Deductible Out-of-Network and are administered as follows:

- Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge.
- The maximum amount payable for an assistant surgeon will be limited to charges that do not exceed 20 percent of the surgeon's allowable charge.
- The maximum amount payable for a co-surgeon will be limited to 62.5 percent of the surgeon's allowable charge.
- Surgical fees under the Out-of-Network guidelines include all of the following:
  - Immediate pre-operative examinations
  - The actual surgical procedure
  - Post-operative care that is required by, and directly related to, the surgical procedure
  - NOTE: The customer may be Balance Billed by an Out-of-Network facility for charges over the Maximum Reimbursable Charge (see page 17 for an explanation of Balance Billing).
- The Plan covers reconstructive cosmetic services (surgery or treatment) only for correction of damage caused by illness, therapeutic surgeries, accident or injuries.
- The Plan covers Medically Necessary surgery to correct a congenital defect such as a cleft palate or a ventricular septal defect performed on a covered dependent.

Surgical Expenses - Anesthesia

Anesthesia charges are administered as follows:

- Benefits will not be provided for anesthesia administered in connection with dental surgery for which benefits are payable under your dental plan.
- If more than one charge is made for the administration of anesthesia in connection with a surgical procedure, those charges will be considered as one charge and will be subject to the anesthesia rate for that procedure.
- Benefits will not be provided for anesthesia administered in connection with any service determined to be cosmetic or otherwise deemed not Medically Necessary.
- Anesthesia performed in conjunction with a routine colonoscopy will be covered under the preventive care benefit at 100%.

Surgical Expenses – Gender Affirmation Surgery

The PPO option includes benefits for gender affirmation surgery. Coverage will be in accordance with Cigna's Medical Coverage Policy for gender affirmation surgery.

Gender Affirmation Surgery - Travel Benefit

The PPO option includes coverage for travel expenses for the recipient and one travel companion. Expenses are reimbursed at 100% up to a combined $10,000 per lifetime maximum. Travel expenses are subject to the same terms and conditions as the transplant travel benefit. However, lodging is limited to $125 per day and meals are not covered.

Charges made for reasonable travel expenses incurred by you in connection with a preapproved surgery are covered subject to the following conditions and limitations. Benefits for transportation and lodging are available to you only if you are the recipient of a preapproved surgery. The term recipient is defined to include a person receiving authorized gender affirmation surgery. Travel expenses for the person receiving the surgery will include charges for: transportation to and from the surgery facility (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 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 or domestic partner, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

Eligible expenses are reimbursed at 100% up to one combined $10,000 maximum per lifetime for recipient and one companion.

Commonly covered expenses while receiving services are:

- Air, rail, ferry or bus travel by commercial carrier to and from the facility
- Automobile rental or use of personal automobile to and from the facility
- Gasoline and parking
- Taxi and shuttle services to and from the facility
- Hotel and housing associated with visits or admissions to the facility

Examples of Non-Covered Items:

- Travel costs incurred due to travel within 60 miles of your home
- Charges for transportation that exceed coach class rates
- Lodging expenses that exceed $125 per day
- Expenses for food, meals or groceries
- Laundry or telephone expenses
- Lost wages due to time off from work required for surgery
- Books, magazines, theater tickets and other items of entertainment
- Loss of money or loss/damage to luggage or clothing
- In-room movies, internet or mini-bar items
- Alcohol or tobacco products
- Over-the-counter medications
- Tolls, fines or traffic tickets
- Deposits for housing, utilities, etc.
- Travel from outside the United States (except for Puerto Rico and the Virgin Islands)

Gender Affirmation Surgery – Tax Implications

Payments for travel and related expenses may be subject to IRS taxable income regulations. Ask your personal tax advisor about the tax consequences of these payments. You will receive a 1099-M form approximately 45 days after the end of the year for travel related expenses if annual travel expenditures reimbursed by the plan exceed $600.

Gender Affirmation Surgery - Claim Processing

Receipts should be attached to a completed claim form with a complete description of the reason for the expense, the individual that incurred the expense, and that the expense is related to gender affirmation surgery. The claim should be mailed to the address on the back of the Cigna ID card. You can download claim forms at www.mycigna.com or call 800 909 2227 to request a claim form and for any questions related to gender affirmation surgery.

Vision Screenings

As a part of routine Preventive Care, a vision screening or vision eye chart test is covered. A vision screening is a brief evaluation (such as with a Snellen – or "big E" – chart) and is performed by a primary care doctor as part of a regular physical. A vision screening does not diagnose or correct vision or eye health issues. Routine vision care including the examination of the eyes, with or without dilation, to determine the health of the eyes and related structures, visual acuity, and determination of the patient's refractive state, corrective lenses and frames are not covered.

In some cases, a routine vision screening can transition to a medical exam if during the course of the examination the eye care professional discovers a condition that requires additional testing or a special diagnostic procedure. In such cases, medical eye care including the examination, treatment and management of an eye condition or disease, such as cataracts, glaucoma, diabetic retinopathy, macular degeneration, infections, eye pain or injury is covered. The first pair of contact lenses for treatment of keratoconus or following cataract surgery also are covered.

For routine screenings, see *Preventive Care* on page 21.

Well Baby Care

The Plan covers In-Network well baby care at 100%. This includes all appropriate office visits and immunizations from birth through 12 months. For well child care after 12 months, see *Preventive Care* on page 21.

OTHER COVERED MEDICAL EXPENSES

Other covered medical expenses include:

- Bariatric surgery for participants and their covered dependents age 18 and over with the surgical need to be determined by a doctor. Surgery is limited to one surgery in a lifetime and is only covered when In-Network Providers or facilities are used and properly authorized and the surgery is determined to be Medically Necessary. Additional limitations may apply
- Gender affirmation surgery and associated counseling along with prescription drug costs. Contact Cigna for detailed information on Plan benefits
- X-ray and radium treatments, including chemotherapy
- Oxygen and its administration
- Blood transfusions, including cost of blood and blood plasma
- Sterilizations and for the employee, Spouse or Domestic Partner only
- Elective and non-elective abortions for the employee and all covered dependents.

WELLNESS PROGRAMS

The PPO Option provides a variety of programs and services to help you maintain or improve your health and well-being.

Health Assessment

- Take an online health assessment and receive a wellness score based on how you compare to people in your gender and age group
- You'll also get recommended next steps to help you get started on a path to better health. And based on your responses, you may also receive a web invitation to join one of Cigna's Online Health Coaching Programs for the support you need to get healthy and stay healthy. Joining is easy, and there's no cost to you
- You can find the health assessment at www.My Cigna.com.

Personal Health Team

Partner with a member of your Personal Health Team to take a more active role in your health. The Personal Health Team includes individuals trained as Nurses, Coaches, Nutritionists, Clinicians and Counselors who will listen, understand your needs and help you find solutions, even when you're not sure where to begin. Connect with your Personal Health Team if you want to:

- Maintain good eating and exercise habits
- Receive support and encouragement to set and reach health improvement goals
- Better manage conditions, including coronary artery disease, low back pain, arthritis, high blood pressure, high cholesterol and more
- Learn skills at your own pace
- Identify triggers to better cope with and reduce stress
- Sleep better
- Increase your physical activity and improve your nutrition

One phone call lets you:

- Get help making decisions for treatment by educating you on your options—so you and your doctor can choose what works best for you
- Access support 24-hours-a-day when you need medical treatment guidance. For example, how to treat your child's high fever
- Understand preventive screenings and annual exams to meet your needs and preferences
- Know what to expect and how to prepare if you need to spend time in the Hospital or need surgery
- Get answers to questions about your benefits and finding your way through the health care system

Health Management

- **Quit Today™** — Get the help and support you need to quit Nicotine Use for good
- **Healthy Steps to Weight Loss™** —Reach your weight loss goals or sustain a healthy weight
- **Strength and Resilience™** — The stress management program can help you cope with stress and avoid stress related illnesses
- **Healthy Pregnancies, Healthy Babies™** — This comprehensive maternity program supports pregnant participants and those considering pregnancy, whether they simply need information about pregnancy and babies, or are identified as high-risk and need specialized case management. The program includes preconception and prenatal education through print and online tools, a comprehensive assessment and development of individualized care plans tailored to your specific needs. If you enroll in your first trimester, Cigna will send you a check for $250 at the completion of the program. If you enroll in your second trimester, Cigna will send you a check for $125 at the completion of the program
- **Your Health First™** — Chronic condition support that provides comprehensive health management tailored to your needs. And it's all delivered through the continuous, personalized support of a dedicated health coach. Conditions include asthma, heart disease, coronary artery

disease, COPD, diabetes, metabolic syndrome/weight complications, peripheral arterial disease, low back pain, osteoarthritis and depression.
- **Cancer Support Program** — Information, assistance and one-on-one support every step of the way from understanding your diagnosis to discussing treatment options identified by your doctor to celebrating survivorship.

Healthy Rewards®

You can access the many online tools located at www.MyCigna.com offering discounts on:
- Weight Management and Nutrition
- Fitness
- Tobacco Cessation
- Vitamins, Health and Wellness Products
- Mind/Body
- Vision and Hearing Care
- Healthy Lifestyle Products
- Alternative Medicine
- Dental Care

Contact Cigna at **www.myCigna.com** or **800 909 2227** for more information.

SPECIAL PLAN PROVISIONS

The following sections describe helpful services available in conjunction with the PPO Option. You can access these services by calling Cigna at 800 909 2227.

CASE MANAGEMENT

Case Management is a service provided through Cigna that 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 Providers, 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 Cigna at 800 909 2227. In addition, your employer, a Cigna customer service representative or a member of Cigna's utilization review or Personal Health Team may refer an individual for Case Management
- Cigna 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.

TRANSPLANT SERVICES - CIGNA LIFESOURCE TRANSPLANT NETWORK®

Transplant Services – Prior Authorization

All transplant services must be properly authorized before admission. (See the *Prior Authorization* section on page 18.)

There is no coverage for Out-of-Network transplant services treatment. In-Network transplant services are covered in accordance with the following:

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

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

All Transplant services, other than cornea, are covered at 100% when received at Cigna LifeSource Transplant Network® facilities. Cornea transplants are not covered at Cigna LifeSource Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LifeSource Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any Out-of Network facilities not specifically contracted with Cigna for Transplant services, are not covered.

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

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and

food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LifeSource Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges also will be considered covered travel expenses for one companion to accompany you. The term companion includes your Spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses: travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates. Travel expenses are limited to a total of $10,000 per transplant for the recipient and one travel companion.

These benefits are only available when the covered person is the recipient of an organ transplant. **No benefits are available when the covered person is a donor.**

EXCLUSIONS

The following expenses are not covered under the Plan. Keep in mind, this is not a complete list. If you have any questions about a specific service contact Cigna at 800 909 2227 or Medco at 800 903 7968 as appropriate so as not to incur a claim denial and any unnecessary Out-of-Pocket expenses.

EXCLUSIONS AND EXPENSES NOT COVERED

- 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, riot or insurrection
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this Plan
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care
- Coverage for or in connection with experimental, investigational or unproven services or supplies. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, Substance Abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
  - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed
  - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use
  - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the Cancer Clinical Trials section on page 23; or
  - The subject of an ongoing phase I, II or III Cancer Clinical Trial, except as provided in the Cancer Clinical Trials section on page 23
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance

- The following services are excluded from coverage regardless of clinical indications: Acupressure; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; and Prolotherapy
- 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. Charges made for services or supplies provided for or in connection with an accidental Injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses. Specifically excluded are: 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
- Unless otherwise covered in this Plan, coverage for reports, evaluations, physical examinations, or Hospitalization not required for health reasons including, but not limited to, school, sports, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations
- Court-ordered treatment or Hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this Plan
- 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 donor sperm and eggs are also excluded from coverage
- Implanted or injected contraceptives except those allowed under the prescription benefit plan as mentioned on page 29.
- Reversal of male or 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 infant child of a dependent, unless this infant child is otherwise eligible under this Plan
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Care” or “Women’s Health and Cancer Rights Act” sections of this Plan
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Care 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, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures

- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound
- Aids or devices that assist with nonverbal communications, including but not limited to 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 and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery)
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy
- All noninjectable prescription drugs, injectable prescription drugs that 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 or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary
- Membership costs or fees associated with health clubs, weight loss programs and 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 or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery
- Blood administration for the purpose of general improvement in physical condition
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks
- Cosmetics, dietary supplements and health and beauty aids
- Nutritional supplements except when due to Phenylketonuria (PKU), and formula except for infant formula needed for the treatment of inborn errors of metabolism
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit
- Telephone, email, and Internet consultations, and telemedicine
- Massage therapy
- The following are specifically excluded from Mental Health and Substance Abuse Services:
    - Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement
    - Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain
    - Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders
    - Counseling for activities of an educational nature
    - Counseling for borderline intellectual functioning
    - Counseling for occupational problems
    - Counseling related to consciousness raising
    - Vocational or religious counseling
    - I.Q. testing
    - Custodial care, including but not limited to geriatric day care
    - Psychological testing on children requested by or for a school system

- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline

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
- To the extent that you or any one of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- To the extent that payment is unlawful where the person resides when the expenses are incurred
- For charges which would not have been made if the person had no insurance
- To the extent that they are more than Maximum Reimbursable Charges
- To the extent of the exclusions imposed by any certification requirement shown in this Plan
- Expenses for supplies, care, treatment, or surgery that are not Medically Necessary
- Charges made by any covered Provider who is a member of your family or your dependent's Family

The prescription drug plan does not cover:

- Non-Federal Legend drugs
- Contraceptive jellies, creams, foams or implants
- Glucowatch and Glucowatch Sensor
- Plan B
- Preven
- Drugs to treat impotency
- Antagon kit
- Cetrotide
- Mifeprex
- Homeopathics
- Non-insulin needles and syringes
- Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth (i.e. Rogaine®, Propecia®) or for cosmetic purposes only (i.e.Renova®, Vaniqa®, Tri-Luma®, Botox cosmetic®, Avage®, Solage®)
- Allergy Sera
- Immunization agents, biologicals and vaccines
- Blood or blood plasma products
- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the customer
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, Skilled Nursing Facility, convalescent Hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the Physician's original order
- Charges for the administration or injection of any drug

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Protection Act (Newborns' Act) is a federal law that includes important protections for mothers and their newborns with regard to the length of the Hospital stay following childbirth.

The law states that only self-insured group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act requires those health plans that have coverage for mastectomies to also provide coverage for reconstructive surgery and Prostheses following mastectomies. Although the current health plan(s) already provide for this coverage, the Act requires that you be notified of the provisions of the law.

The law mandates that any individual covered under the group health plan who receives benefits for a Medically Necessary mastectomy and who elects breast reconstruction after the mastectomy, will also receive coverage for:

- The reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other (unaffected) breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

Coverage should be provided in consultation with the attending Physician and the patient. Benefits provided under this Plan will be subject to the same annual Plan Deductibles and all applicable co-insurance/co-pay provisions that apply to the mastectomy.

CONTINUED COVERAGE

HOW TO CONTINUE YOUR COVERAGE

If certain qualifying events cause you and/or your covered dependent(s) to lose PPO Option coverage, you and/or your covered dependent(s) may continue coverage for a limited period of time by electing COBRA, retiree, or continuation coverage. The chart below summarizes the coverage options.

CONTINUED COVERAGE	BRIEF DESCRIPTION OF MEDICAL COVERAGE
COBRA	The same medical coverage you and/or your covered dependents had on the day before regular coverage ended is available for up to 18 months, or in some cases, up to 29 or 36 months.
Retiree	The same medical coverage you and/or your covered dependents had on the day before regular coverage ended is available up to age 65, if certain age and service requirements are met. For more information, see the *Eligibility for Retiree Coverage* section.
Domestic Partner Continuation Coverage	Domestic partners and their children who lose coverage under certain circumstances may be eligible to continue their coverage. COBRA coverage is not available; however, under Sodexo's Domestic Partner policies, Domestic Partner continuation coverage may be available. Coverage time frames, costs and administration procedures will generally be the same as for COBRA coverage. Call 877 633 9837 with any questions.

If you choose COBRA, continuation coverage or retiree coverage, Sodexo will provide you with the same coverage provided to active employees and their family members. This means that if the coverage for active employees and their family members is modified, your coverage also will be modified. You may continue the same coverage you had at the time COBRA, retiree or continuation coverage began, but you may not add coverage or switch to another medical plan until the following Annual Enrollment. Although COBRA, continuation coverage or retiree coverage provides you with the same coverage as active employees, the cost for your coverage is higher. For more information, see the *Cost of COBRA Coverage* section.

COBRA COVERAGE

COBRA continuation coverage and retiree coverage are administered by Benefit Concepts on behalf of Sodexo. You may call Benefit Concepts at 800 969 2009 with questions.

Eligibility for COBRA

You and/or your dependents who were active Participants in the PPO Option on the day before active coverage was lost (because of one of the events listed in the following chart) are eligible for COBRA. When coverage is lost because you leave your job to perform military service, COBRA coverage is offered to you and your covered dependents for up to 24 months.

INITIAL QUALIFYING EVENTS AND LENGTH OF COBRA		
When coverage is lost because…	**COBRA is offered To…**	**For…**
• Your employment ends voluntarily or involuntarily • You become ineligible for coverage due to a reduction in your hours of employment	You and your covered dependents	Up to 18 months*
• You die	Your covered	Up to 36

• You and your covered Spouse legally separate or divorce	dependents	months
• Your dependent child becomes ineligible for coverage due to age **	Your covered Child	Up to 36 months

*The coverage may increase to 29 months if you (or a covered dependent) are disabled at the time of or within 60 days after the date COBRA coverage begins. State regulations may also allow you to extend your length of coverage.

**You must call 877 633 9837 within 60 days; otherwise your dependents will not be eligible for COBRA coverage.

Second Qualifying Events and Length of COBRA

Your qualified beneficiaries may extend coverage for *up to 36 months* (measured from the date of the initial event) if one of the following second qualifying events occurs while they are receiving COBRA benefits:

- You and your Spouse divorce, legally separate or have your marriage annulled
- Your child becomes ineligible
- You die

The second event can only be a second qualifying event if it would have caused you to lose coverage under the Plan in the absence of the first qualifying event.

Extended Coverage

State regulations may allow you to extend the length of coverage, but increased premiums may apply. For more information, call Benefit Concepts at 800 969 2009.

You may not elect COBRA coverage on behalf of a divorced Spouse, but he or she may personally elect to continue coverage. To extend COBRA coverage for divorce, legal separation, annulment or loss of dependent status, you or your dependents must notify Benefit Concepts in writing within 60 days of a second qualifying event. Otherwise, your dependents will lose the right to continue COBRA coverage beyond the original 18- or 29-month COBRA coverage period.

How to Enroll for COBRA Coverage

The Plan Administrator will automatically send a COBRA notice and enrollment form if you and your covered dependents lose coverage because of:

- Termination of your employment
- Reduction in your hours of employment
- Your death

You must call 877 633 9837 *within 60 days* after your divorce, legal separation or your child's loss of eligibility to receive a COBRA notice and election form for coverage of your formerly eligible dependents. If you do not call within the 60-day period, the dependent's coverage *cannot* be continued under COBRA.

To elect COBRA, you must complete and return the enrollment form within 60 days from the date of the notice. If COBRA coverage is not elected within the time allowed, coverage will end on the date stated in the COBRA notice. To continue COBRA coverage, you must pay the monthly premiums specified in the notice.

How to Add a Dependent to COBRA Coverage

You may add eligible dependents to your coverage during Annual Enrollment. You may also add a newly eligible dependent (for example, a newborn child or a Spouse) to your COBRA coverage during the Plan Year. Send your request for coverage for the new dependent, in writing, to Benefit Concepts *within 45 days* of the event (for example, date of birth or marriage) with the appropriate documentation.

You must notify Benefit Concepts of any changes to your (or your dependent's) address.

Cost of COBRA Coverage

Each Participant who continues coverage under COBRA must pay the full cost of coverage, plus 2% for administrative expenses. In general, premium payments for COBRA change at the beginning of each new Plan Year.

COBRA coverage is paid in monthly premiums, which are due on the first day of each month. The first payment must be made within 45 days after COBRA coverage is elected and is applied retroactive to the date coverage was lost. Once you are enrolled and have paid your first premium, you will receive premium payment coupons for monthly payments. Payments not received within 30 days after the premium is due (or, if later, 45 days after COBRA coverage is elected) will result in loss of coverage retroactive to the day before the premium was due. Once coverage is terminated for nonpayment, it cannot be reinstated.

The federal government will periodically pass laws that impact COBRA coverage and the associated costs. Sodexo will always comply in a timely manner with any federally mandated changes to COBRA.

Special Rules for Disabled Qualified Beneficiaries

If you or a covered dependent (who was originally eligible for COBRA) was disabled for Social Security purposes on or within 60 days after the date that your employment or your eligibility for coverage ended, the COBRA period may be extended for you and your qualified beneficiaries until 29 months from the initial qualifying event or the end of the month following the month in which the disabled individual ceases to be disabled, whichever is earlier. Your COBRA period also may be extended if a child born to, placed for adoption with, or adopted by you during the period you are receiving COBRA coverage becomes disabled for Social Security purposes within 60 days after the birth or adoption of that child.

For coverage to be extended, a copy of the disabled Participant's Social Security Disability Award Letter must be mailed to Benefit Concepts:

- Within 60 days of the COBRA notice, if the award letter was issued before your employment ended or your hours were reduced
- Within 60 days of the date of the award letter and before the end of the 18-month COBRA period, if the award letter was issued after your employment ended or your hours were reduced

If the Social Security Administration subsequently determines that the disabled Participant is no longer disabled, Benefit Concepts must be notified within 30 days of the Social Security Administration's final determination. Once Benefit Concepts is notified, it will cancel coverage

retroactive to when the Participant was no longer considered disabled. The Participant may be liable for any claims after that date.

Costs for Disabled Qualified Beneficiaries

Your COBRA coverage premium will increase to 150% of the cost of coverage for active employees for any period that the disabled individual receives COBRA coverage, beginning with the 19th month of COBRA coverage and continuing until COBRA coverage terminates. That means, for the first 18 months of COBRA coverage you would pay 102% of the Plan's cost of coverage monthly, and for any portion of the remaining coverage period during which the disabled individual receives COBRA coverage, you would pay 150% of the Plan's cost of coverage monthly.

If you experience a second qualifying event after the 18th month, and extend your coverage to the maximum of 36 months from the first qualifying event, you will continue to pay at the 150% rate for months 30 through 36 if you continue COBRA coverage of the disabled individual. However, if the second qualifying event occurs within the original 18-month period of coverage, you will not be charged more than 102% of the Plan's cost of coverage at any time during the COBRA coverage period. If you elect to continue COBRA coverage, but the disabled individual does not elect COBRA coverage, your premiums will remain at 102% of the Plan's cost of coverage for the entire 29-month period.

Loss of COBRA Coverage

COBRA coverage for you or your covered dependents may stop before the maximum coverage period ends if any of the following happen:

- You (or your covered dependent) do not pay the monthly premium when due
- You (or your covered dependent) become covered after the date you elect COBRA coverage under any other group health plan, and:
  - The Plan has no exclusions or limitations regarding that Participant's own Pre-Existing Conditions (if any); or
  - The Participant is not subject to the Plan's exclusions or limitations
- You (or your covered dependent) first become covered by Medicare on or after the date you elect COBRA coverage (but only with respect to the Participants who are covered by Medicare)
- The medical plan is terminated with no substitute provided
- Coverage was extended for up to 29 months because of a covered Participant's disability and it is determined that the covered Participant is no longer disabled
- You (or your covered dependent) voluntarily cancel coverage
- You become covered by another employer's health plan
- You (or your covered dependent) die

Questions About COBRA Coverage

If you have questions about COBRA coverage, please call or write to:

Benefit Concepts
P.O. Box 246
Barrington, RI 02806-0246
800 969 2009

Please print your name, address and a reference to Sodexo on all correspondence.

RETIREE COVERAGE

If you are eligible, you may elect retiree medical coverage (instead of COBRA coverage) for yourself and/or your covered dependents. Retiree coverage is the same medical coverage in effect on the day before your regular coverage ended. This means that if the coverage for active employees and their family members is modified, your coverage also will be modified. However, during Annual Enrollment, you may switch to another medical plan.

EXAMPLE
If you retired within 12 months of your 65th birthday, you could have retiree coverage for up to 12 months, but COBRA coverage for 18 months.

Eligibility for Retiree Coverage

You are eligible for retiree coverage if, on the date you retire, you meet all of the following requirements:

- You are under age 65
- You are at least age 55 with ten years of continuous service
- You were hired before Dec. 31, 1986, and actively on the payroll prior to Dec. 31, 2007, and your age plus length of service is equal to or greater than 75 on or before Dec. 31, 2007

Retiree coverage is not available if, after you elect retiree coverage, you begin working for Sodexo or any other employer (including yourself) on a full-time basis and other group health coverage is available to you through your employer.

INITIAL QUALIFYING EVENTS AND LENGTH OF RETIREE COVERAGE*

If...	Retiree coverage may be elected...	For how long...
• You retire • Your employment ends • You become ineligible for coverage due to a reduction in your hours of employment to part-time, temporary or pool status	By you for yourself and your covered dependents	You—up to age 65 Your Spouse—up to age 65 provided your Spouse remains an eligible dependent Your children—until they are no longer eligible dependents
• On the date of your death, you were eligible for retiree coverage, but had not yet retired and elected coverage • You were eligible for retiree coverage before age 65, but did not elect the coverage because you retired after age 65	By your covered dependents	Your Spouse—up to age 65 provided your Spouse remains an eligible dependent Your children—until they are no longer eligible dependents

*This chart assumes that you are eligible for retiree coverage.

How to Enroll in Retiree Coverage

Benefit Concepts will automatically send a retiree coverage notice and enrollment form if you and your covered dependents lose coverage because of your retirement. To enroll in retiree coverage, complete and return the election form with your first payment to Benefit Concepts within 60 days following the date of your notice. If retiree coverage is not elected within the time allowed, coverage will end on the date stated in the notice. To continue coverage, you must pay the monthly premiums specified in the notice.

Special Circumstances

Although retiree coverage is usually available to you and your covered dependents for a longer period than COBRA coverage, in some cases, retiree coverage may be available to you for a shorter time period than COBRA coverage.

How to Add a Dependent to Retiree Coverage

You may add eligible dependents to your coverage during Annual Enrollment. You may add newly eligible dependents (for example, a newborn child or a Spouse) to your retiree coverage during the Plan Year. Send your request for coverage for the new dependent, in writing, to Benefit Concepts within 45

days of the event (for example, date of birth or marriage) with the appropriate documentation. You must notify Benefit Concepts of any changes to your (or your dependent's) address.

Cost of Retiree Coverage

The cost of retiree coverage is the same as the cost for COBRA coverage. For details, see *Cost of COBRA Coverage* on page 48.

QUALIFYING EVENTS DURING RETIREE COVERAGE		
If the following events occur while you are receiving retiree coverage...	**Retiree coverage may be extended for up to an additional 36 months...**	**For...**
You and your covered Spouse divorce or legally separate (whichever is first)	From the date of divorce or legal separation	Your covered Spouse and children
Your covered child becomes ineligible due to age	From the date your child becomes ineligible	Your covered child
You die and your Spouse or child began coverage after the date you retired	From the date of your death	Your covered Spouse and children

You or your dependents must notify Benefit Concepts in writing within 60 days of the divorce, legal separation or loss of dependent status. Otherwise, coverage will not extend beyond the original retiree coverage period.

When Retiree Coverage Ends

Retiree coverage ends when any of the following occur:

- You turn 65 (your covered dependents may continue coverage if they are still eligible)
- Your request to cancel coverage is received
- The required premium is not paid when due
- You return to full-time employment and other group plan coverage becomes available to you through your employer
- Sodexo no longer offers health care coverage to its employees
- Coverage was extended due to a covered person's disability, and it is determined that the covered person is no longer disabled
- When other group plan coverage becomes available for your covered Spouse
- You (or your covered dependent) die

Costs for Disabled Qualified Beneficiaries

The cost of retiree coverage for disabled qualified beneficiaries is the same as their cost for COBRA coverage. For details, see *COBRA Coverage*.

Questions About Retiree Coverage

If you have questions about retiree coverage, please call or write to:

Benefit Concepts
P.O. Box 246
Barrington, RI 02806-0246
800 969 2009

Please print your name, address and a reference to Sodexo on all correspondence.

CLAIMS

HOW TO FILE A CLAIM FOR BENEFITS

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 or your authorized representative must send your completed claim form and itemized bills to the claims address listed on the claim form. You can get the required claim forms from www.myCigna.com or by calling Cigna at 800 909 2227.

CLAIM REMINDERS

Be sure to use your Customer ID and Account/Group Number when you file Cigna's claim forms, or when you call the 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 on the back of the claim form when submitting a claim to Cigna.

TIMELY FILING OF OUT-OF-NETWORK CLAIMS

Cigna will consider claims for coverage when 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 Stay, 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. You will receive a written notice from Cigna regarding your claim based on the response time listed in the table below:

BENEFIT DECISIONS	
Type of Request	**Response Time**
Urgent Pre-Service Medical Necessity Determination A request for an expedited review for a required Medical Necessity determination prior to care when delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment	Decisions will be made within 72 hours from receipt of the request
Pre-Service Medical Necessity Determination A request for a required Medical Necessity determination prior to care	Decisions will be made within 15 days from receipt of the request, but no longer than 30 days if an extension is needed
Concurrent Medical Necessity Determination When an ongoing course of treatment has been approved, and you are requesting to extend the approval	Decisions will be made within 24 hours from receipt of the request
Post-Service Medical Necessity Determination A request for a required Medical Necessity determination after services have been received	Decisions will be made within 30 days from receipt of the request, but no longer than 45 days if an extension is needed
Post-Service Claim A claim for benefits for services which have been received	Decisions will be made within 30 days from receipt of the claim for benefits but no longer than 45 days if an extension is needed

BENEFIT REVIEW AND DETERMINATION

If you or your authorized representative fail to provide the necessary information needed to determine whether, or to what extent, benefits are covered or payable under the Plan:

- **Urgent Pre-Service Medical Necessity Determination Request**
  Cigna will notify you or your authorized representative as soon as possible but not later than 24 hours after receipt of the request of the specific information needed to complete the claim. You or your authorized representative will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours to provide the specified information. Cigna will notify you or your authorized representative of the expedited benefit determination within 48 hours after you or your representative responds to the request for information.

- **Pre-Service and Post-Service Medical Necessity Determinations and Post-Service Claims**
  Cigna will notify you or your authorized representative of the specific information needed. You or your authorized representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends a notice of missing information, and will resume on the date you or your authorized representative responds to the request for information.

If your pre-service or concurrent care Medical Necessity determination or post-service Medical Necessity determination or claim is denied, you will receive a written notice including a description of any additional material or information you must provide and information on how to request a review of the decision. If you do not receive a written notice about your request for benefit determination or claim within the appropriate time period, you can call Cigna at 800 909 2227 to make sure it was received and/or file an appeal.

CLAIMS PAID IN ERROR

If benefit payments to you or on your behalf are greater than the amount that should have been paid, the Plan Administrator and Cigna have the right and obligation to recover the excess amount. If any excess payments cannot be recovered from you or the Provider, the Plan Administrator has the right to take appropriate legal action to recover erroneous payments, including payments that should have been made by a plan that was primary to the plan in which you participate.

FILING DIRECT CLAIMS FOR PRESCRIPTION DRUGS

Under most circumstances, you will not need to file a claim for your prescriptions. However, your Plan provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. This claim will be processed based on your Plan benefit. In the rare case you need to submit your own post-service claim for reimbursement, follow these steps:

- Log on to Medco at www.medco.com
- If you are not already a registered customer, you will need to register
- In the top left corner under “Prescriptions & Benefits” click on “Forms and Cards”
- Click on “Claim forms for retail pharmacy purchases” and download the claim form

You can contact Medco directly for assistance at 800 753 2851. Send your claim to:
Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

URGENT CARE CLAIMS FOR PRESCRIPTION DRUGS

In the case of a claim for coverage involving Urgent Care, you will be notified of the benefit determination within 24 hours of receipt of the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim will be deemed denied.

APPEALS

You may file an appeal if you believe that your request for eligibility in the PPO Option under the Sodexo Medical Plan has been administered improperly or your claim for medical benefits has been denied incorrectly.

ELIGIBILITY APPEALS

If you feel that your request to participate in the PPO Option has been administered incorrectly, you may request a review of the situation by sending a written appeal within 60 days of notification to:

Sodexo Benefits
Appeals Coordinator
P.O. Box 44309
Jacksonville, FL 32231-4309

A decision will be provided by Sodexo Benefits within 10 business days providing all information needed to make the decision is provided by the claimant or other third party. If you are not satisfied with Sodexo Benefit's review and response, you are entitled to a final review by filing a written appeal with the Plan Administrator at:

Sodexo, Inc.
Benefit Operations
9801 Washingtonian Blvd., Suite 119
Gaithersburg, MD 20878

You must make your written appeal to the Plan Administrator within 60 days of the date you receive the first level appeal denial letter. Detail your reasons for the appeal and include any copies of documents or records that support your position. A decision will be issued within 10 business days providing all information needed to make the decision is provided by the claimant or other third party.

Urgent Medical Claims Eligibility Appeals

If your eligibility appeal is related to an urgent medical care claim for you or your eligible dependent, call 877 633 9837 for an expedited review of the eligibility portion of the appeal. A decision will be issued as soon as possible, but not later than 72 hours after the appeal is received, as long as all information needed to make a decision is provided by the claimant or other third party.

BENEFIT CLAIMS APPEALS — CIGNA

If your claim is denied (for example, if your claim for benefits is determined to be not medically necessary), or if your coverage is rescinded:

- you will be provided with a written notice of the denial or rescission; and
- you are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim or medical necessity determination is denied, the Claims Administrator will provide in writing a notice of the Adverse Benefit Determination (denial) that will include all of the following that pertain to the determination:

- Information sufficient to identify the claim involved
- The specific reason(s) for the denial
- A reference to the specific Plan provision(s) on which the Claims Administrator's determination is based
- A description of any additional material or information needed to perfect your claim
- An explanation of why the additional material or information is needed
- A description of the Plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA if you appeal and the claim denial is upheld
- 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
- 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
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you

For claims involving urgent determinations/concurrent care:

- The Claims Administrator's notice will include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator may notify you or your authorized representative orally within 72 hours for urgent determinations or within 24 hours for concurrent care and then furnish a written notification.

HOW TO FILE AN APPEAL OF AN ADVERSE BENEFIT DETERMINATION

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

Start With Customer Service

If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call Cigna at 800 909 2227 and explain your concern to one of our Customer Service representatives. You may also express that concern in writing.
Cigna will do its best to resolve the matter on your initial contact. If Cigna needs more time to review or investigate your concern, they will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call Cigna at 800 909 2227.

How Your Appeal will be Decided

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 Provider.

A decision regarding your appeal will be made according to the following timelines.

CIGNA LEVEL-ONE APPEALS			
Type of Appeal	**Definition**	**Your Timeline**	**Cigna's Timeline**
Urgent*	A request to expedite your appeal if the standard time periods for making non-Urgent Care determinations could seriously jeopardize the life or health of the claimant, or the ability of the claimant to regain maximum function, or in the opinion of a Physician with the knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.	Appeal must be received within 365 days after you are notified of the denial or rescission.	A decision will be issued orally within 72 hours after receipt of the claimant's request for review of an Adverse Benefit Determination.
Pre-Service or Concurrent Care	An appeal to overturn a benefit denial determination that was made prior to the service being performed.	Appeal must be received within 365 days after you are notified of the denial or rescission.	Cigna will review within 15 days. **
Post-Service	An appeal to overturn a claim that was denied after the service was performed.	Appeals must be received within 365 days after you are notified of the denial or rescission.	Cigna will review within 30 days. **

*If an Urgent Care claims appeal is contingent on an eligibility appeal, the eligibility appeal will be handled in the same way as an Urgent Care claims appeal.

If you are not satisfied with the level-one review, you may request a level-two review of any claims that were denied after your first written appeal. Your letter requesting a level-two appeal should include the reasons for the appeal and copies of any documents or records that support your position, including any factors that you believe were not considered on the first appeal and any additional pertinent information that may have been received after you filed your first appeal.

CIGNA LEVEL-TWO APPEALS			
Type of Appeal	**Definition**	**Your Timeline**	**Cigna's Timeline**
Urgent*	A request to expedite your appeal if the standard time periods for making non-Urgent Care determinations could seriously jeopardize the life or health of the claimant, or the ability of the claimant to regain maximum function, or in the opinion of a Physician with the knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.	Appeal must be received within 365 days after you are notified of the denial or rescission.	A decision will be issued orally within 72 hours after receipt of the request for review of an Adverse Benefit Determination, followed by written notification.
Pre-Service or Concurrent Care	An appeal to overturn a benefit denial determination that was made prior to the service being performed.	Appeal must be received within 365 days after you are notified of the denial or rescission.	Cigna will review within 15 days.**
Post-Service	An appeal to overturn a claim that was denied after the service was performed.	Appeals must be received within 365 days after you are notified of the denial or rescission.	Cigna will review within 30 days. **

*If an Urgent Care claims appeal is contingent on an eligibility appeal, the eligibility appeal will be handled in the same way as an Urgent Care claims appeal.

Requests for a level-two appeal regarding the medical necessity or clinical appropriateness of your issue will be conducted by a Committee, which consists of one or more people not previously involved in the prior decision. The Committee will consult with at least one Physician 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.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level-two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the Committee's decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the Committee's decision so that you will have an opportunity to respond. You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting, and within the review time frames above if the Committee does not approve the requested coverage.

External Review

If you have participated in the level one and level two appeals processes and you are not fully satisfied with the decision of Cigna's level-two appeal review you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare, or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant's rights to any other benefits under the Plan.

There is no charge for you to initiate this Independent Review Process. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level-two appeal denial notification. Cigna will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna's Physician Reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, but you have not yet been discharged from a facility, the review shall be completed within 72 hours.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing, and if it is an adverse determination it will include:

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

Relevant Information

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

Legal Action

You have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level-one and level-two appeal processes. If your appeal is expedited, there is no need to complete the level-two process prior to bringing legal action.

Benefit Claims Appeals — Medco

If your claim for prescription drug benefits is denied, you have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. Your Adverse Benefit Determination notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any, considered by the Plan in relation to your appeal, the Plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes.

You have the right to receive, upon request and at no charge, the information used to review your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal (or with respect to urgent the decision made after your first level appeal) is final and binding.

MEDCO PRESCRIPTION CLAIMS APPEALS

Type of Appeal	Your Timeline	Medco's Timeline
Urgent Appeal*	Call Medco at 800 753 2851	Medco will review within 72 hours. (*There is only one level of internal appeal for Urgent Care claims*)
First Level	Appeal must be received within 180 days of receipt of notice of the initial coverage decision	Medco will review within 15 days for non-urgent appeals (*72 hours for urgent appeals*)
Second Level	Appeal must be received within 90 days of receipt of the notice of the decision at the first level of appeal	Medco will review within 30 days
External Review	Appeal must be received within 180 days of the decision at the second level of appeal	An Independent Review Organization (IRO) will review within 30 days

*An urgent appeal is any claim for treatment in which the time periods for making non-Urgent Care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a Physician with the knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed.

FOR ALL MEDCO CLAIMS APPEALS

To submit an appeal, include in writing your:

- Name
- Member ID
- Phone number
- Prescription drug for which benefit coverage has been denied the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes)
- Any additional information that may be relevant to your appeal

Send your appeal to:
Medco Health Solutions, Inc.
PO Box 631850
Irving, TX 75063-0030

Urgent appeal requests may be oral or written. You or your Physician can call 800 753 2851 to request an appeal or send your appeal to the address above.

Urgent Care Appeals

You have the right to request an urgent appeal of a claim denial (including a deemed denial). Urgent appeal requests may be oral or written.

In the case of an appeal for denial of a claim involving Urgent Care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding.

Non-Urgent First-Level Claim Appeal

In the event you receive an Adverse Benefit Determination (your claim is denied) following a request for coverage of a prescription benefit claim, you have the right to appeal the Adverse Benefit Determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your Physician). A decision regarding your appeal will be sent to you within 15 days of receipt of your written request.

Non-Urgent Second-Level Claim Appeal

For a non-urgent appeal, if you are not satisfied with the coverage decision made on appeal, you can request in writing, within 90 days of the receipt of notice of the decision, a second-level appeal. A second-level appeal may be initiated by you or your authorized representative (such as your Physician). A decision regarding your appeal will be sent to you within 30 days of receipt of your written request.

If your second-level appeal is denied and you are not satisfied with the decision of the appeal (or first level of appeal in the case of an urgent appeal), you also have the right to request an external review in writing by following the instructions on the enclosed External Appeal Filing Form you will receive with your final internal appeal denial. If you have any questions or concerns during the external review process, you can call the toll-free number included in your final appeal denial. You can submit additional written comments to the external reviewer. More details on your external review rights are provided below.

External Review For Prescription Drug Claims on Appeal

You also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an Adverse Benefit Determination. External reviews are not available for decisions relating to eligibility.

For external review for urgent claims, your situation must meet the definition of urgent under the law. If your situation is urgent your review will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your life or health or ability to regain maximum function may be in serious jeopardy or, in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, and you have submitted a request for internal appeal, you may be entitled to simultaneously submit a request for external review. Your request for expedited external review can be initiated by calling the toll-free number provided in your Notice of Adverse Benefit Determination letter.

For external review for non-urgent claims, you must submit your request within four (4) months of the denial. Please note: If the date that is four (4) months after the adverse determination falls on a Saturday, Sunday or holiday, then you have until the next day that is not a Saturday, Sunday or holiday to submit your request. If there is no day that is 4 months after the date of your adverse determination (e.g., where your determination date is October 30 and there is no February 30), then you have until the first day of the 5th month after the date of the adverse determination to submit your request (in the above example, March 1).

The information you'll need to request an external appeal will be provided on the enclosed External Appeal Filing Form you will receive with your second level appeal denial. The minimal information required in a request for external review includes:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- if you are requesting an urgent review, any reasons why the appeal should be processed on a more expedited basis.

Requirement to File an Appeal Before Filing a Lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If your appeal as described above ultimately results in an Adverse Benefit Determination, you have a right to bring a civil action under Section 502(a) of ERISA.

COORDINATING WITH OTHER PLANS

If you and your Spouse both work, your family may be covered by more than one group medical Plan. The medical portion of your PPO Option plan coordinates its payments with payments you may receive from other group insurance plans under which you or your dependents are covered. The following types of plans coordinate with your PPO medical coverage:

- Group insurance through your Spouse's employer
- Group insurance through a professional or fraternal association
- Motor vehicle insurance (your own or any other responsible party's)
- Other group insurance plans to which you and your dependents belong

The PPO Option does not coordinate payments with individual medical insurance. The prescription drug portion of your coverage does not have a Coordination of Benefits provision available.

HOW TO DETERMINE WHICH PLAN IS PRIMARY

In general, your Plan will be considered primary for:

- Employees
- Covered dependents when the employee's birthday falls before his or her Spouse's birthday in a calendar year

The Birthday Rule

When dependents are covered under two medical plans, insurance companies use the birthday rule to determine which parent's plan will be considered primary. In general, the employee whose birthday comes first in the calendar year will be considered primary. If both parents have the same birthday, the plan that covered the parent for a longer time will be primary. If the other plan has not adopted this birthday rule, the plan of the father will be primary to the plan of the mother.

If You Are Divorced or Separated

If parents are divorced or legally separated, the following determines primary/secondary payment responsibilities for the dependent child:

- If there is a court decree or legally recognized child support agreement:
  - The plan of the parent with financial responsibility for the child's health care expenses by court decree or legally recognized child support agreement pays first; any other plan that covers the child as a dependent pays second.
- If there isn't a court decree or legally recognized support agreement and the parent with custody of the child has NOT remarried:
  - The plan of the parent with custody of the child pays first; the plan of the parent without custody pays second.
- If there isn't a court decree or legally recognized support agreement and the parent with custody of the child HAS remarried:
  - The plan of the parent with custody of the child pays first; the step-parent's plan pays second; and then the plan of the parent without custody pays last.

When the Other Plan Is Automatically Primary

Any other plan will be primary if it:

- Does not have a Coordination of Benefits provision
- Is a program required by law
- Is a motor vehicle insurance policy (In certain states, the motor vehicle insurance policy permits you to designate your group plan as primary. If this applies to you, you must submit written proof to Cigna that you have designated your PPO Option plan as primary.)

If none of the rules above apply, then the plan that has covered the person for the longer period of time will be primary.

HOW THE PLAN PAYS COORDINATED BENEFITS

If your plan is primary, it will pay benefits without regard to the secondary plan's benefits. Your plan will consider the charges first. If your plan is secondary, benefits will be determined as follows:

- If the amount you are entitled to receive from all other coverage is the same as or greater than what your plan would have paid if it had been the only coverage, your plan will not pay any benefits.
- If the amount you are entitled to receive from all other coverage is less than what your plan would have paid if it had been the only coverage, your plan will pay benefits. Payments will be calculated as if your plan were primary and then reduced by the benefits you are entitled to receive from the other plans.

EXAMPLE

(The examples that follow assume your Spouse is using an In-Network doctor under the PPO Option):

You and your Spouse both have family coverage through your respective employers. Your Spouse goes to the doctor and the bill for the office visit is $40. Your Spouse's plan pays $32, leaving a balance of $8. Under the PPO Option, if it were the only plan, you would pay your $20 copay and the Plan would pay $20. Since your Spouse's plan paid more than the benefit for this service under your plan, the PPO Option would pay no benefit. See a summary of the calculations below:

PPO Option Payment Calculation		
Office Visit Charge	$40	
Minus Copay for Service	- $20	
PPO Option Benefit before Coordination	$20	
Minus Primary Plan Payment	- $32	($32 is more the PPO Option's benefit of $20)
PPO Option Benefit Payable after Coordination	$0	

However, if the cost for the office visit is $100, and your Spouse's plan pays $50—leaving a balance of $50, then under the PPO Option, if it were the only plan, you would have paid your $20 copay and the PPO Option would have paid $80. Since your Spouse's plan paid less than the benefit for this service under your plan, the PPO Option would pay $30. See a summary of the calculations below:

PPO Option Payment Calculation		
Office Visit Charge	$100	
Minus Copay for Service	- $20	
PPO Option Benefit before Coordination	$80	
Minus Primary Plan Payment	- $50	($50 is less than the PPO Option benefit of $80)
PPO Option Benefit Payable after Coordination	$30	

Coordination with Medicaid

For Medicaid Participants, charges covered by the Plan will be paid according to any assignment of rights required by Medicaid. Unless otherwise permitted by law, payments of charges covered under the plans will be made without consideration of benefits due under Medicaid. The prescription portion of the PPO Option does not coordinate with Medicaid. If either you or a dependent covered by the PPO Option is entitled to Medicare, please see *How the PPO Option Works with Medicare* on page 64 for coverage information.

HOW TO FILE CLAIMS UNDER TWO PLANS

If benefits are payable under two plans, file claims first with the primary plan. After you receive an Explanation of Benefits (EOB) statement from the primary plan's insurance carrier, submit the claim and EOB statement to the secondary plan's insurance carrier.

THIRD-PARTY LIABILITY

If you incur medical expenses for which another party may be liable, the claim will be processed as usual. However, by enrolling in the PPO Option, you agree to:

- Transfer your rights to recover damages and/or settlements in full to the Plan for any medical expenses for which another party may be liable
- Permit the Plan to act on your behalf to collect these damages and/or settlements from the other party
- Reimburse the Plan in full if you receive any damages and/or settlements directly from the other party

The Plan's right of full recovery either through Subrogation and/or reimbursement for medical expenses for which another party may be liable may be from the funds of any third-party settlement including, but not limited to:

- Any liability or other insurance coverage
- The insured's own uninsured or underinsured motorist coverage
- Any medical payments
- Any no-fault or school insurance coverage that is paid or payable

EXAMPLE

You are injured in a car accident that is not your fault and receive benefits under the PPO Option to treat your injuries. Under third-party recovery, the Plan would have the right to take legal action against the insurance carrier of the other driver, in your name, to recover the cost of the covered medical services provided to you. This means that if you received a settlement from the insurance company, you would have to reimburse the Plan for the amount it paid to cover your related medical expenses. If the award of damages or settlement does not specify the portion applied to medical expenses, Cigna will apply the amount due from the other party to medical expenses first. You are solely responsible for paying any attorney's fees or other legal fees that you incur in third party liability situations. Cigna may administer this provision through any appropriate method, means, or source it deems appropriate.

HOW THE PPO OPTION WORKS WITH MEDICARE

The PPO Option coordinates its benefits with Medicare for those employees entitled to Medicare. Please be aware, Medicare has specific enrollment periods and effective dates. If you do not enroll when you are first eligible, you may find yourself without medical coverage if your PPO Option were to end for any reason. You also may be subject to lifetime penalties for to enrolling when you are first eligible. Please visit the Medicare website at www.medicare.gov for more information.

If You Are an Active, Full-Time Employee

If you are an active, full-time employee enrolled in the Plan, and you (or a covered dependent) are eligible for Medicare, you can continue to participate in the Plan as long as you *remain* an active, full-time employee. You have the following coverage options:

- PPO Option coverage only
- PPO Option and Medicare coverage
- Medicare coverage only

If You Are Not an Active, Full-Time Employee

Depending on when you were entitled to Medicare, you may be eligible for benefits if you are eligible for COBRA or retiree coverage.

If you lose your medical coverage because you leave the Company or your hours are reduced to part-time, temporary, or pool status and...	Then:
You (or your covered dependent) were entitled to Medicare *before* coverage ended	You (or your covered dependent) are eligible for COBRA, continuation coverage or retiree coverage (if you meet all other eligibility requirements).
You (or your covered dependent) become entitled to Medicare *before* electing COBRA, continuation coverage or retiree coverage	You (or your covered dependent) are eligible for COBRA, continuation coverage, or retiree coverage (if you meet all other eligibility requirements).
You become entitled to Medicare *after* you have elected COBRA coverage	You are ineligible to continue your COBRA coverage; however, your covered dependents may continue COBRA or continuation coverage.
You become entitled to Medicare *after* you have elected retiree coverage	Retiree coverage ends when you become entitled to Medicare. Your covered dependents are eligible to continue your retiree coverage.
Your covered dependent becomes entitled to	Your dependent is ineligible to continue COBRA or

Medicare *after* COBRA or continuation coverage is elected	continuation coverage.
Your covered dependent becomes entitled to Medicare *after* retiree coverage is elected	Your dependent is ineligible to continue retiree coverage.

Please note that your covered dependents who are not entitled to Medicare may be eligible for COBRA, continuation coverage or retiree coverage. Please see the applicable sections in this document to determine whether your dependents satisfy the eligibility requirements for such coverage options.

COORDINATION OF COVERAGE

When you (or a covered dependent) have both Medicare coverage and coverage under the PPO Option, benefit payments are coordinated between the two plans. The federal government has established the following primary/secondary coordination guidelines:

If the Person Eligible for Medicare Is...	Your PPO Option Is...	And Medicare Is...
An active employee or dependent	Primary	Secondary
An active employee or dependent with end-stage renal disease	Primary for the first 30 months, beginning with the month the Participant first becomes entitled to Medicare	Primary after the first 30 months
Covered by COBRA or continuation coverage and become entitled to Medicare (even if caused by end-stage renal disease)	Terminated	Primary
Covered by COBRA or continuation coverage and became entitled to Medicare *before* electing COBRA or continuation coverage	Secondary	Primary
Eligible for COBRA or continuation coverage and became entitled to Medicare *before* electing COBRA or continuation coverage and has end-stage renal disease	Primary for the first 30 months, beginning with the month the Participant first becomes entitled to Medicare	Primary after the first 30 months
A retiree or a dependent younger than age 65 who is entitled to Medicare for reasons other than having end stage renal disease	Secondary	Primary
A retiree or a dependent with end-stage renal disease	Primary for the first 30 months, beginning with the month the Participant first becomes entitled to Medicare	Primary after the first 30 months

For retirees and their dependents, Plan payments will be reduced by the benefits available under Medicare Parts A, B or D whether or not the Participant was entitled to Medicare.

When the PPO Option is the secondary plan, both of the following guidelines will govern benefit administration:

- If Medicare pays for expenses that are not covered under the Plan, those payments will not be used in reducing the Plan's benefits
- For services and supplies for which Medicare directly reimburses the Provider, the amount of eligible expenses under the Plan will be determined on the basis of the amount approved by Medicare

OTHER IMPORTANT PLAN INFORMATION

YOUR ERISA RIGHTS

As a Participant in the Plan, you are entitled to rights and protection provided by the Employee Retirement Income Security Act of 1974 (ERISA). Under ERISA, all Plan Participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified locations, all Plan documents, and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator, who can require 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 Participant with a copy of the summary annual report.
- Continue health care coverage for yourself, Spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

In addition to creating rights for the Plan Participants, ERISA imposes duties upon the people responsible for the operation of the Plan. The people who operate the Plan, called *fiduciaries*, have a duty to do so prudently and in the interest of you and other Plan Participants. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA. If your claim for a welfare benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file a suit in a federal court. In such cases, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them, unless they were not sent for reasons beyond the Plan Administrator's control.

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.

If the Plan's named 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 costs and legal fees, for example, if it finds your claim is frivolous.

Upon written request, the Plan Administrator will furnish any Plan Participant with information as to whether a particular subsidiary is included in the Plan, and, if so, the subsidiary's address.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact:

- The nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory
- The Division of Technical Assistance and Inquiries, Office of Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC, 20210

PLAN ADMINISTRATION INFORMATION	
Type of Plan	Welfare Benefit Plan
Plan Identification Number	511
Plan Administrator	Sodexo, Inc. Corporate Benefits Department 9801 Washingtonian Boulevard Gaithersburg, MD 20878
Employer Identification Number	52-0936594
Fiduciary	Sodexo, Inc. 9801 Washingtonian Boulevard, 11th Floor Gaithersburg, MD 20878
Agent for Service of Legal Process	Senior Vice President & General Counsel Sodexo, Inc. 9801 Washingtonian Boulevard, 12th Floor Gaithersburg, MD 20878
Plan Year	January 1 – December 31
Plan Funding	The Plan is self-funded and is financed by contributions from participating employees and Sodexo, Inc.

FUTURE OF THE PLAN

Employees who participate in the Plan agree to accept the provisions of the Plan as they are today, or as they may be amended in the future. Participants will be informed in a timely manner of any major Plan changes.

The Company intends to continue the Plan indefinitely. However, because unforeseen circumstances may arise, the Company reserves the right to terminate the Plan and to amend or modify the provisions of the Plan at any time. The Plan may be amended from time to time as authorized by the Senior Vice President and Chief Human Resources Officer. The Plan gives the Plan Administrator sole, absolute, and final discretion to determine eligibility for Plan benefits, to construe the terms of the Plan, and to resolve any factual issues relevant to eligibility.

NO CONTRACT OF EMPLOYMENT

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time. Either you or the Company may terminate the employment relationship at any time for any reason.

GOVERNING DOCUMENTS

The Sodexo Medical Plan document will govern in the event of any conflict between the provisions of the Plan and this booklet.

GLOSSARY OF TERMS

Adverse Benefit Determination
Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate.

Examples of Adverse Benefit Determination:
- The care does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness
- The services were determined to be experimental or investigational
- The services were not covered based on any Plan exclusion or limitation

Types of Adverse Benefit Determination:
- Standard: pre-service or post-service
- Urgent/Expedited: pre-service or concurrent care

After-Tax Contributions
Contributions you make for your coverage after Social Security, federal and most state taxes are taken out of your paycheck. Domestic partner contributions for the PPO Option are made on an After-Tax basis. All other PPO Option contributions are made on a Before-Tax basis.

Annual Enrollment
A period of time, typically each fall when you can enroll in Sodexo's benefit plans or change your benefit elections. The changes take effect the following Plan Year, usually on January 1.

Balance Billing
Any expenses above the Maximum Reimbursable Charge for Out-of-Network services. These expenses are your responsibility.

Before-Tax Contributions
Contributions you make for your coverage before Social Security, federal and most state taxes are taken out of your paycheck. The exception is for Domestic Partner contributions which are deducted on an After-Tax basis.

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

Brand Name Drugs
A prescription drug that has a trade name and is protected by a patent (can be produced and sold only by the company holding the patent). Brand name drugs are typically more expensive to develop, therefore they tend to cost more than Generic Drugs.

Clinical Trials
Clinical trials are one form of clinical research that involves a researcher or researchers who directly observe a person or people, and/or who collect data to answer a scientific or medical question about the safety or potential benefit of an intervention such as a medication, device, teaching concept, training method, or behavioral change.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, is a federal law that requires most employers sponsoring group health plans to offer employees and their families the opportunity to temporarily extend their health care coverage (continuation coverage) at group rates in certain instances when coverage under the Plan would otherwise end.

Coinsurance
The percentage you pay for covered medical expenses. The amount of your Coinsurance depends on whether you use in- or Out-of-Network Providers. The remaining percentage is funded by Sodexo.

Company
Sodexo Inc., and any subsidiary authorized to participate in the PPO Option under the Sodexo Medical Plan.

Continued Coverage
Continued coverage generally refers to COBRA coverage, retiree coverage or Domestic Partner continuation coverage.

Continued Stay Review (CSR)
A process used to certify the Medical Necessity and length of a Hospital Stay when you or your dependent require treatment in a Hospital:

- as a registered bed patient;
- for a partial hospitalization for the treatment of mental health or Substance Abuse;
- for mental health or Substance Abuse residential treatment services.

You or your dependent should request Pre-Admission Certification prior to any non-emergency treatment in a Hospital. In the case of an emergency admission, you should contact Cigna within 48 hours after the admission. For an admission due to pregnancy, you should call Cigna by the end of the third month of pregnancy. If you require a stay beyond the original limit certified by your Pre-Admission Certification, you should request Continued Stay Review prior to the end of your certified length of stay, in order to continue coverage for a Hospital Stay.

Benefits will not be paid for Hospital charges for any days in excess of the number of days certified through Continued Stay Review. Continued Stay Review is performed through a utilization review program through Cigna.

Contracted Rate
The Contracted Rate is the dollar amount Cigna has contracted with its In-Network Providers for the services they render. For example: An In-Network doctor bills Cigna $100 for an office visit and the Contracted Rate for this type of service is $80. The customer is liable for the $20 Copay and Cigna reimburses the Provider $60. The remaining $20 is absorbed by the Provider.

Coordination of Benefits
The medical portion of your PPO Option coordinates its payments with payments you may receive from other group insurance plans under which you or your dependents are covered. The following types of plans coordinate with your PPO Option medical coverage:

- Group insurance through your Spouse's employer
- Group insurance through a professional or fraternal association
- Motor vehicle insurance (your own or any other responsible party's)
- Other group insurance plans to which you and your dependents belong

The Plan Administrator recognizes any of the following for the purpose of coordinating benefits:

- Coverage under a governmental plan as required or as provided by law. This does not include a state plan under Medicaid or any law or plan when, by law, its benefits are in excess of those of any private insurance program or other non-governmental program

- Group insurance or other coverage for individuals in a group, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. This does not include school accident-type coverage for grammar school, high school and college students
- Dental care coverage under the no-fault or medical payments provisions of an automobile insurance contract.

The PPO Option does not coordinate payments with individual medical insurance. **The prescription drug portion of your coverage does not have a Coordination of Benefits provision.**

Copay
A Copay (or Copayment) is a fixed fee that subscribers must pay for a specific medical service covered by the Plan.

Copay Plus Coinsurance
The Plan Participant pays a combination of a set Copay and Coinsurance or the remaining cost of a prescription drug.

Covered Expenses
The charges for Medically Necessary services and supplies you receive that are covered under the Plan.

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.

Deductible
The amount you need to pay in covered health expenses before the Plan begins paying a percentage of your costs.

Domestic Partner
To qualify for Domestic Partner status, the employee and partner must meet all of the following criteria:

- Declare they are each other's sole Domestic Partner and have a committed relationship intended to be of indefinite duration
- Not be legally married to anyone else
- Be at least 18 years old
- Not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which they legally reside
- Reside together in the same residence and intend to do so indefinitely
- Be jointly responsible for each other's common welfare and share financial obligations

Sodexo recognizes Domestic Partners of same sex and opposite sex.

Durable Medical Equipment (DME)
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, respirators, wheel chairs, and dialysis machines.

Emergency Medical Condition
Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Services
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, including ancillary services routinely available to the emergency department to evaluate the 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, to stabilize the patient.

ERISA
The Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Experimental/Investigational Treatment
Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, Substance Abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided for as an acceptable Clinical Trial under the Plan.

Explanation of Benefits (EOB)
A written statement that outlines the payment or denial of a medical claim.

External Prosthetic Appliances
Coverage for External Prosthetic Appliances includes the initial purchase and fitting of External Prosthetic Appliances and devices available only by prescription that are necessary for the alleviation or correction of Injury, Sickness or congenital defect.

External Prosthetic Appliances and devices shall include Prostheses/Prosthetic Appliances and Devices, Orthoses and Orthotic Devices; Braces; and Splints. Prostheses/Prosthetic Appliances and Devices are defined as fabricated replacements for missing body parts. Orthoses and Orthotic Devices are defined as Orthopedic Appliances or Apparatuses used to support, align, prevent or correct deformities. 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. A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Family and Medical Leave Act (FMLA)
The Family and Medical Leave Act (FMLA) of 1993, as amended, requires employers with more than 50 employees to provide eligible workers with up to 12 weeks of unpaid leave each year for births, adoptions, foster care placements and illnesses.

Formulary Drugs
To remain cost effective for Participants, the PPO Option offers a lower Copay for only those drugs on a special list called a formulary. For more information about which drugs are listed on the PPO Option formulary, call Medco.

Full-time Frontline Employee (Class 6)
A non-temporary, full-time frontline (class 6) employee who works 30 or more hours per week for six or more weeks out of each quarter.

Generic Drugs
A drug, approved by the FDA, which has the same chemical composition as a specific Brand Name Drug. Generic drugs may be sold under more than one name and by more than one company.

Global Maternity Fee
With a Global Maternity Fee, your Physician receives one lump sum for your basic prenatal care. This lump sum is based on your Physician's Contracted Rate with the insurance company. If you have a complicated pregnancy that requires more than basic prenatal care, your Physician will get paid separately for the services above and beyond the standard rates.

Home Health Care Agency
An agency or organization that provides a program of home health care and is approved under Medicare or is established and operated according to applicable licensing and other laws. If it does not meet either of these two requirements, it *must* meet all of the following criteria:
- Be primarily designed to provide a home health care delivery system bringing supportive services to the home
- Have a full-time administrator
- Maintain written records of services provided to the patient
- Be staffed by at least one Registered Nurse (R.N.) or offer nursing care provided by an R.N.
- Have bonded employees and provide malpractice insurance

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.

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.

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 institution which: specializes in treatment of Mental Health and Substance Abuse or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

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

Hospital Stay or Confinement

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 Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

Injury

The term Injury means an accidental bodily Injury.

In-Network

Each time you or your family members need medical care, you decide if you want to use In-Network or Out-of-Network Providers. In-Network Providers are screened by Cigna for education, experience, credentials and commitment to managing overall patient care. In-Network Providers have agreed to provide their services at a Contracted Rate and your Out-of-Pocket expenses are typically lower. The chart on page 18 shows you the differences in benefits and features when care is received In- and Out-of-Network.

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 Cigna at 800 909 2227 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.

Imputed Income

PPO Option contributions for Domestic Partners and Domestic Partner's children are made on an After-Tax basis. This is accomplished through the use of Imputed Income. Benefit contributions are taken out of your paycheck on a Before-Tax basis but reflected as income your W-2 forms.

PPO Option Before-Tax Contributions and Company contributions toward Domestic Partner coverage will be considered taxable income to you and will be subject to Social Security, Medicare, and federal income tax withholding, and state and local income tax withholding where applicable. This amount will be reported to the IRS as part of your wages on each pay stub and additional income taxes and FICA (Social Security and Medicare) taxes will be withheld from your paycheck on this Imputed Income.

Leave of Absence

Employer approved period of time for which you are absent from work or duty.

Lifetime Maximum

The most a Plan will pay per person during a lifetime for all Covered Expenses incurred by the Plan including prescription drugs. **There is no Lifetime Maximum for coverage under the PPO Option.**

Long-term Medication
Medications that you take on a regular basis, such as those for high blood pressure, diabetes or birth control.

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

Maximum Reimbursable Charge
The Maximum Reimbursable Charge for covered services is determined based on the lesser of:
- the Provider's normal charge for a similar service or supply; or
- 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.

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.

Medically Necessary
Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:
- 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 care Provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

Military Leave of Absence
Generally, you may perform service in the uniformed services for a cumulative period of up to five years and retain reemployment rights with Sodexo. The position to which you will be restored depends on how long you have been on leave. If your unit has closed or your position has been eliminated because of a reduction in force while you were in military service, Sodexo may not be able to reemploy you.

USERRA protects members of the "uniformed services" which means the U.S Armed Forces including reservists; the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training; or full-time National Guard duty the commissioned corps of the Public Health Service; and any other category of person designated by the President in time of war or national emergency. USERRA applies to all Sodexo employees, whether full-time or part-time.

Necessary Services and Supplies
The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during a Hospital Stay, any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.

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

Network
A Physician, Hospital, or other Provider of medical services or supplies that has signed an agreement or contract with Cigna to provide medical or surgical services and supplies to Cigna Open Access Plus/CareLink Participants. Such services may be furnished for predetermined amounts.

Nicotine Use
For purposes of assessing the nicotine surcharge, Nicotine Use is the use of tobacco products within the last 12 months in such forms as cigarettes, pipes, cigars, snuff or chewing tobacco. As it relates to the Sodexo Inc. Medical Plan, using smoking cessation products that contain nicotine is not considered Nicotine Use.

Note: *The Nicotine Surcharge is not applicable to employees covered by a collective bargaining agreement or covered under COBRA coverage. If you have questions regarding whether this applies to you, call 877 633 9837.*

Nurse
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.

Other Health Care Facility/Other Health Professional
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. 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.

Orthoses and Orthotic Devices
Orthopedic Appliances or Apparatuses used to support, align, prevent or correct deformities.

Out-of-Network
Each time you or your family members need medical care, you decide if you want to use In-Network or Out-of-Network Providers. Out-of-Network Providers have not been screened by Cigna for education, experience, credentials and commitment to managing overall patient care. Out-of-Network Providers have not agreed to provide their services at a Contracted Rate and your Out-of-Pocket expenses will typically be higher. When you use an Out-of-Network Provider you will be responsible for any expenses above the Maximum Reimbursable Charge for Out-of-Network services, also called Balance Billing. The chart on page 18 shows you the differences in benefits and features when care is received In- and Out-of-Network.

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 Cigna at 800 909 2227 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.

Out-of-Pocket Maximum
To protect you and your family from the cost of a catastrophic illness or accident, the Plan has an Out-of-Pocket Maximum. This means the amount you pay each Plan Year for covered medical expenses is limited. Once you reach the Out-of-Pocket Maximum, the Plan will pay 100% of most covered services for you for the remainder of the Plan Year. Certain expenses do **not** count toward the Out-of-Pocket Maximum including charges for:

- Office visit Copays
- Your paycheck deductions
- The $75 emergency room Copay
- The $20 Urgent Care services Copay
- Expenses over the Maximum Reimbursable Charge

- Any penalties for not adhering to Prior Authorization requirements (if applicable)
- Prescription drug Copays or Coinsurance
- Any non-covered services

Once you reach the Out-of-Pocket Maximum, you are still responsible for paying the items listed above. The Plan Year Deductible will count toward meeting the Out-of-Pocket Maximum.

Participant
An employee or dependent eligible to participate in the Plan whose election to participate in the Plan has become and remains effective.

Participating Provider
A Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the Participant is covered.

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).

Physician
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.

Physician Reviewer
A licensed Physician depending on the care, service or treatment under review.

Plan
PPO Option under the Sodexo Medical Plan administered by Cigna using the Cigna Open Access Plus/CareLink product with Cigna's nationwide Provider Network

Plan Year
January 1 – December 31.

Pre-Admission Certification (PAC)
A process used to certify the Medical Necessity and length of a Hospital Stay when you or your dependent require treatment in a Hospital:
- as a registered bed patient;
- for a partial hospitalization for the treatment of mental health or Substance Abuse;
- for mental health or Substance Abuse residential treatment services.

You or your dependent should request Pre-Admission Certification prior to any non-emergency treatment in a Hospital. In the case of an emergency admission, you should contact Cigna within 48 hours after the admission. For an admission due to pregnancy, you should call Cigna by the end of the third month of pregnancy.

If Pre-Admission Certification is not received for each separate admission to the Hospital, a $500 penalty will be charged and will be removed from the amount paid for Covered Expenses. This also applies to emergency admissions that are not certified within 48 hours of the date of the admission.

Benefits will not be paid for:

- Hospital charges for any days in excess of the number of days certified through Pre-Admission Certification; and
- Hospital charges for which Pre-Admission Certification was requested, but was not certified as Medically Necessary.

Pre-Admission Certification is performed through a utilization review program through Cigna.

Pre-Existing Condition

Any physical and/or mental condition that existed before your enrollment for coverage under a plan. The PPO Option does not have any Pre-Existing Condition exclusions.

Preferred Provider Organization (PPO)

A plan that offers a Network of doctors and facilities. Each time you need medical care, you may visit a Network Provider and receive a higher level of benefits. If you decide to go outside the Network for care, coverage will be provided at a lower level.

Preventive Treatment

Treatment rendered to prevent disease or its recurrence.

Primary Care Physician

A Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and who has been selected by you, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured dependents.

Prior Authorization

Requirement for a particular medication to be approved in advance by the doctor and/or prescription plan. Without this preauthorization, the drug will not be covered.

Prostheses/Prosthetic Appliances

Fabricated replacements for missing body parts.

Provider

A licensed practitioner of the healing arts practicing within the scope of his or her license. Providers include medical doctors, surgeons, podiatrists, certified Nurse-Midwives, Chiropractors, Nurse/Practitioners, Psychiatric Nurses and Psychiatric Social Workers. Under the Plan, Christian Science Practitioners and Homeopathic Practitioners are *not* considered Providers.

Psychologist

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.

Qualified Medical Child Support Order (QMCSO)

A judgment, decree or order issued by a court or through an administrative process that has the force and effect of state law providing for child support or health benefit coverage.

Sickness – For Medical Insurance

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.

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.

Specialist
The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine or pediatrics.

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

Spouse
A legally married person of the opposite sex who is a husband or wife.

Subrogation Claims
Claims in which another party (health insurance company, government program or other third party) are truly responsible for processing and reimbursing. These types of claims are investigated by an outside vendor that will research the liability of the third party by investigating what claims have actually been paid by Cigna.

Substance Abuse
Any use of alcohol and/or drugs that produces a pattern of pathological use causing impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or withdrawal.

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.

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March 2012