



## **SUMMARY PLAN DESCRIPTION**

Basic and Premier Medical Plans

(Administered by Cigna)

**EFFECTIVE DATE: January 1, 2013**

ASO15  
3335055

This document printed in April, 2013 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

## **City of Memphis**

MEDICAL BENEFITS  
Basic Plan and Premier Plan  
(Administered by Cigna)

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## **Important Information**

WE ARE PLEASED TO PROVIDE YOU WITH THE CITY OF MEMPHIS (PLAN ADMINISTRATOR/ SPONSOR) SUMMARY PLAN DESCRIPTION (SPD) FOR THE MEDICAL PLAN. THE PURPOSE OF THE DOCUMENT IS TO GUIDE YOU THROUGH UNDERSTANDING HOW TO ACCESS THE SERVICES AND BENEFITS AVAILABLE TO YOU.

THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-FUNDED OR SELF-INSURED BY CITY OF MEMPHIS MEANING WE ARE RESPONSIBLE FOR THE DESIGN AND COST OF THE PLAN. WE HAVE CONTRACTED WITH CIGNA (CLAIMS ADMINISTRATOR), A THIRD PARTY ADMINISTRATOR TO PRIMARILY PAY OUR CLAIMS AND TO HAVE USE OF THEIR NATIONAL PROVIDER NETWORK.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

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**Explanation of Terms**

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

**The Schedule**

**The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.**

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## Special Plan Provisions

When you select a Participating Provider (In Network Provider), this Plan pays a greater share of the costs than if you select a non-Participating Provider (Out of Network Provider). Participating Providers, include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

### Services Available in Conjunction With Your Medical Plan

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

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### Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

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

- You, your dependent or an attending Physician can request Case Management services by calling the **toll-free number** shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

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

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## Important Notices

### Notice of Grandfathered Plan Status (does not apply to Vision)

This plan is being treated as a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care

Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the phone number or address provided in your plan documents, to your employer or plan sponsor or an explanation can be found on Cigna's website at [http://www.Cigna.com/sites/healthcare\\_reform/customer.html](http://www.Cigna.com/sites/healthcare_reform/customer.html).

If your plan is a nonfederal government plan or a church plan, you may also contact the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov).

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## How To File Your Out-of-Network Claim

There is no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by calling Member Services using the toll-free number on your identification card.

### CLAIM REMINDERS

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

## Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 12 months for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 12 months for Out-of-Network benefits, the claim will not be considered valid and will be denied.

**WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

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## Eligibility - Effective Date

### Eligibility for Employee and Retiree Insurance

An Eligible Person is a regular scheduled full-time employee of the Plan Sponsor and eligible retirees. Other individuals approved by the City of Memphis (Airport Authority, Federal Credit Union, Center City, Police Reserves) may be allowed coverage provided they meet all requirements that City employees and/or retired employees must meet for coverage. The City reserves the right to amend this section from time to time at its discretion and agrees to give 60 days written notice of termination of coverage to the group. Termination of coverage by either party will be deemed termination of coverage for all members, retired or active, in the group.

### Effective Date of Your Insurance

First of the month following 30 days after receipt of the enrollment form(s).

## Dependent Insurance

### Effective Date of Dependent Insurance

Your Dependents will be insured only if you are insured.

### Exception for Newborns

Any Dependent born to you while you are insured will become insured on the date of his birth provided that you elect coverage for him no later than 60 days after his birth. If you do not elect to insure your new dependent within 60 days, no benefits will be payable for that dependent.

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## When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

### How to Enroll

To enroll, the Eligible Person must complete an enrollment form. The Plan Sponsor will provide you with the enrollment form and instructions for submitting it along with any necessary documentation. We will not provide Benefits for health services that you receive before your effective date of coverage.

## Who is Eligible for Coverage

### Eligible Person \*

Eligible Person usually refers to an employee who meets the eligibility rules. When an Eligible Person actually enrolls, The City of Memphis refers to that person as a Participant. If both spouses are Eligible Persons under the Plan, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both. Except as we have described in this section, “When Coverage Begins”, Eligible Persons may not enroll. We, City of Memphis, determine who is eligible to enroll under the Plan.

### Dependent \*

Dependent generally refers to the Participant's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see the section called “Definitions”.

- Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.
- If both parents of a Dependent child work for the city and are enrolled as a Participant, only one parent may enroll the child as a Dependent. Two Plan Participants who are married to each other can choose to enroll in two (2) single Plans or one (1) family Plan..

Except as we have described in this section, “When Coverage Begins,” Dependents may not enroll without our written permission. We, City of Memphis, determine who qualifies as a Dependent.

## When to Enroll and When Coverage Begins

### Open Enrollment Period \*

Eligible Persons may enroll themselves and their Dependents. The City of Memphis determines the Open Enrollment Period. Coverage begins on the date identified by City of Memphis if the completed enrollment form and any required documentation is received within the designated Open Enrollment Period.

### New Eligible Employees \*

New Eligible Persons may enroll themselves and their Dependents.

Coverage begins on the first day of the month following the completion of a 30 day waiting period if the Plan Administrator receives the properly completed enrollment form and any required contribution for coverage within 31 days of the date the new Eligible Person becomes eligible.

### Adding New Dependents \*

Participants may enroll Dependents who join their family because of any of the following events:

- Birth. Newborns will not automatically be covered. Newborns are not covered until they have been enrolled by the employee.
- Legal adoption.
- Placement for adoption.
- Marriage
- Legal guardianship.
- Court or administrative order.

Coverage begins on the date of the event if City of Memphis received the completed enrollment form and any required contribution for coverage within 60 days of the event that makes the new Dependent eligible.

### When Participant Retires

An eligible retired employee and his/her eligible dependents are included for medical care coverage provided healthcare coverage was in force immediately prior to retirement and remains in continuous force. If you do not elect to remain in this plan at retirement or if you cancel coverage after retirement you waive your enrollment rights forever.

### Surviving Widowed Spouses and Children

Are eligible to continue coverage if coverage was in force prior to retiree’s death. If you do not elect to remain in the plan at retiree’s death or you cancel coverage in the future you waive your enrollment rights forever.

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### Special Enrollment Period/Qualifying Life Events

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following qualifying life events occurs:

- Birth.
- Legal Adoption.
- Placement for adoption.
- Marriage.
- Divorce or Legal Separation.
- Loss of Coverage due to Job Change or Reduction in Hours.
- Loss of Coverage through Medicaid or Children's Health Insurance Program (CHIP).

Coverage begins on the first day of the month following the completion of a 30 day waiting period if the Plan Administrator receives the properly completed enrollment form and any required contribution for coverage within 60 days of the date the new Eligible Person becomes eligible to enroll.

## Healthcare Surcharges

### Spousal Surcharge:

A spousal surcharge will apply and is assessed in addition to your healthcare premium if you choose to cover a spouse under your health plan.

The surcharge can be waived if the City's plan will be your spouse's secondary coverage; if your spouse is unemployed; or if your spouse does not have access to coverage through his/her employer. You must provide the City with a notarized affidavit along with the required documentation proving your spouse has primary coverage, is unemployed or does not have access to another employer's sponsored health plan or Medicare. The surcharge is only waived if the affidavit and required documentation is received during the open enrollment period or during the time of a qualifying life event.

Random audits to verify compliance will occur and will be done by an outside audit firm.

### Tobacco/Nicotine Surcharge:

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A tobacco surcharge is assessed in addition to the healthcare premium and applies to all family members age 16 and over.

The City must have a notarized affidavit on file stating that no members of the family use tobacco or nicotine of any kind in order to have the tobacco surcharge waived. Currently, one (1) tobacco surcharge is assessed per family per pay period regardless to the number of nicotine users in the family.

If you should stop using tobacco/nicotine in the future, you can have your surcharge stopped at anytime as long as you can provide a negative nicotine test result that was performed by a certified lab (at your expense) along with a notarized affidavit. NOTE: There is no refund of previous surcharges but we will stop deductions at the time all required documentation is received.

To monitor compliance, the City has chosen an independent audit firm to conduct random nicotine testing of any participant age 16 and over who has indicated on the affidavit that they are non-tobacco/nicotine users. If you are randomly chosen for testing, everyone in the family 16 years or older will have to comply in order for the City to continue waiving your surcharge.

**NOTE: If the random samples result in negative findings for either nicotine usage or spousal accessibility, participants will be reprimanded up to and including termination of healthcare coverage and the participant will be required to repay all surcharges waived during the time period of the inaccurate information. Surcharge(s) will resume for all participants who refuse to comply with the request of the audit firm.**

## City of Memphis Premier Plan Benefits

### The Schedule

#### For You and Your Dependents

City of Memphis Premier Plan Benefits provide coverage for care In-Network and Out-of-Network. To receive City of Memphis Premier Plan Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

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

#### Coinsurance

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

#### Copayments/Deductibles

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

#### Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%:

- Coinsurance.

Once the Out-of-Pocket Maximum is reached for covered services that apply to the Out-of-Pocket Maximum, any copayments and/or benefit deductibles are no longer required.

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Non-compliance penalties.
- Plan Deductible.
- Any copayments and/or benefit deductibles.
- Provider charges in excess of the Maximum Reimbursable Charge.

#### Accumulation of Plan Deductibles

Deductibles do not cross-accumulate (that is, In-Network will accumulate to In-Network and Out-of-Network will accumulate to Out-of-Network). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.

#### Multiple Surgical Reduction

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

## City of Memphis Premier Plan Benefits

### The Schedule

#### Assistant Surgeon and Co-Surgeon Charges

##### Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

##### Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Lifetime Maximum</b>	Unlimited	
<b>Coinsurance Level</b>  <b>Note:</b> "No charge" means an insured person is not required to pay Coinsurance.	The plan pays 100%.  You do not pay Coinsurance.	The plan pays 60% of the Maximum Reimbursable Charge.  You pay 40% plus any additional amount billed by the provider in excess of the Maximum Reimbursable Charge.
<b>Calendar Year Deductible</b>  Individual Family Maximum  Note: The plan deductible is waived for members when this plan is secondary for the purposes of coordination. Family Maximum Calculation <b>Individual Calculation:</b> Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.	\$100 per person  \$300 per family	\$500 per person  \$1,500 per family

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Out-of-Pocket Maximum</b></p> <p>Individual</p> <p>Family Maximum</p> <p>Family Maximum Calculation</p> <p><b>Individual Calculation:</b></p> <p>Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.</p>	<p>Not Applicable</p> <p>Not Applicable</p>	<p>\$3,000 per person</p> <p>\$7,000 per family</p>
<p><b>Physician's Services</b></p> <p>Primary Care Physician's Office Visit</p> <p>Specialty Care Physician's Office Visits</p> <p>    Consultant and Referral Physician's Services</p> <p><b>Note:</b></p> <p>OB/GYN providers will be considered as a PCP.</p> <p>Surgery Performed in the Physician's Office</p> <p>Second Opinion Consultations (provided on a voluntary basis)</p> <p>Allergy Treatment/Injections</p> <p>Allergy Serum (dispensed by the Physician in the office)</p>	<p>You pay \$20 per office visit copay and plan deductible</p> <p>You pay \$40 Specialist per office visit copay and plan deductible</p> <p>You pay \$20 PCP or \$40 Specialist per office visit copay and plan deductible</p> <p>You pay \$20 PCP or \$40 Specialist per office visit copay and plan deductible</p> <p>No charge</p> <p>No charge</p>	<p>You pay 40% after plan deductible</p>
<p><b>Preventive Care</b></p> <p>Note: for Vision exam, see page 43 for details.</p> <p><b>Note:</b></p> <p>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.</p> <p>Routine Preventive Care - all ages</p> <p>Immunizations - all ages</p>	<p>No charge</p> <p>No charge</p>	<p>In-Network coverage only</p> <p>In-Network coverage only</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Mammograms, PSA, PAP Smear</b> Preventive Care Related Services (i.e. "routine" services) Diagnostic Related Services (i.e. "non-routine" services)	No charge  No charge	In-Network coverage only  You pay 40% after plan deductible
<b>Inpatient Hospital - Facility Services</b>  Semi-Private Room and Board  Private Room  Special Care Units (ICU/CCU)	You pay \$100 per admission copay, then plan deductible  Limited to the semi-private room negotiated rate  Limited to the semi-private room negotiated rate  Limited to the negotiated rate	You pay \$300 per admission copay, then 40% after plan deductible  Limited to the semi-private room rate  Limited to the semi-private room rate  Limited to the ICU/CCU daily room rate
<b>Outpatient Facility Services</b> Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room  <b>Note:</b> Non-surgical treatment procedures are not subject to the facility copay.	You pay \$100 per visit copay, then plan deductible	You pay 40% after plan deductible
<b>Outpatient Therapeutic Treatments</b> Includes dialysis, intravenous chemotherapy and other infusion therapies	You pay \$20 per day copay, then plan deductible	You pay 40% after plan deductible
<b>Inpatient Hospital Physician's Visits/Consultations</b>	You pay plan deductible	You pay 40% after plan deductible
<b>Inpatient Hospital Professional Services</b>  Surgeon Radiologist Pathologist Anesthesiologist	You pay plan deductible	You pay 40% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Outpatient Professional Services</b> Surgeon Anesthesiologist Radiologist Pathologist	You pay plan deductible  No charge	You pay 40% after plan deductible  You pay 40% after plan deductible
<b>Emergency and Urgent Care Services</b> Hospital Emergency Room Urgent Care Facility or Outpatient Facility X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit) Independent x-ray and/or Lab Facility in conjunction with an ER visit Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	You pay \$100 per visit copay* and plan deductible You pay \$30 per visit copay and plan deductible *waived if admitted No charge No charge No charge	You pay \$100 per visit copay* and plan deductible You pay \$30 per visit copay and plan deductible *waived if admitted No charge No charge No charge
<b>Ambulance</b> <b>Note:</b> Emergency transportation by ground or air. Non-Emergency transportation requires prior-authorization	You pay plan deductible	You pay plan deductible
<b>Inpatient Services at Other Health Care Facilities</b> Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 70 days combined	You pay plan deductible	You pay 40% after plan deductible
<b>Laboratory and Radiology Services (includes pre-admission testing)</b> Physician's Office Visit Outpatient Hospital Facility Independent X-ray and/or Lab Facility	No charge No charge No charge	You pay 40% after plan deductible You pay 40% after plan deductible You pay 40% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</b></p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p>	<p>No charge</p> <p>You pay \$100 per admission copay, then plan deductible</p> <p>You pay plan deductible</p>	<p>You pay 40% after plan deductible</p> <p>You pay \$300 per admission copay, then 40% after plan deductible</p> <p>You pay 40% after plan deductible</p>
<p><b>Outpatient Short-Term Rehabilitative Therapy</b></p> <p>Calendar Year Maximum: 60 days for all therapies combined</p> <p>Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy</p>	<p>You pay \$20 PCP or \$40 Specialist per office visit copay and plan deductible</p> <p><b>Note:</b> Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.</p>	<p>You pay 40% after plan deductible</p>
<p><b>Outpatient Cardiac Rehabilitation</b></p> <p>Calendar Year Maximum: 36 days</p>	<p>You pay \$20 PCP or \$40 Specialist per office visit copay and plan deductible</p>	<p>You pay 40% after plan deductible</p>
<p><b>Chiropractic Care</b></p> <p>Calendar Year Maximum: 20 days</p> <p>Physician's Office Visit</p>	<p>You pay \$20 PCP or \$40 Specialist per office visit copay and plan deductible</p>	<p>In-Network coverage only</p>
<p><b>Home Health Care</b></p> <p>Calendar Year Maximum: Unlimited (includes outpatient nursing when approved as medically necessary)</p>	<p>You pay plan deductible</p>	<p>You pay 40% after plan deductible</p>
<p><b>Hospice</b></p> <p>Inpatient Services</p> <p>Outpatient Services (same coinsurance level as Home Health Care)</p>	<p>You pay plan deductible</p> <p>You pay plan deductible</p>	<p>You pay 40% after plan deductible</p> <p>You pay 40% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Bereavement Counseling</b> Services provided as part of Hospice Care</p> <p>Inpatient</p> <p>Outpatient</p> <p>Services provided by Mental Health Professional</p>	<p>You pay plan deductible</p> <p>You pay plan deductible</p> <p>Covered under Mental Health Benefit</p>	<p>You pay 40% after plan deductible</p> <p>You pay 40% after plan deductible</p> <p>Covered under Mental Health Benefit</p>
<p><b>Maternity Care Services</b></p> <p><b>Note:</b> Plan does not cover maternity care for pregnant dependent children. Benefit only available for pregnant Employee or Dependent Spouse.</p> <p>Initial Visit to Confirm Pregnancy</p> <p><b>Note:</b> OB/GYN providers will be considered as a PCP.</p> <p>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)</p> <p>Delivery - Facility (Inpatient Hospital, Birthing Center)</p>	<p>You pay \$20 PCP per office visit copay and plan deductible</p> <p>No charge</p> <p>You pay \$100 per admission copay, then plan deductible</p>	<p>You pay 40% after plan deductible</p> <p>You pay 40% after plan deductible</p> <p>You pay \$300 per admission copay, then 40% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Abortion</b> Includes only non-elective procedures</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p>	<p>You pay \$20 PCP or \$40 Specialist per office visit copay and plan deductible</p> <p>You pay \$100 per admission copay, then plan deductible</p> <p>You pay \$100 per visit copay, then plan deductible</p>	<p>You pay 40% after plan deductible</p> <p>You pay \$300 per admission copay, then 40% after plan deductible</p> <p>You pay 40% after plan deductible</p>
<p><b>Women's Family Planning Services</b></p> <p>Office Visits, Lab and Radiology Tests and Counseling</p> <p><b>Note:</b> Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.</p> <p>Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>You pay 40% after plan deductible</p> <p>You pay 40% after plan deductible</p> <p>You pay \$300 per admission copay, then 40% after plan deductible</p> <p>You pay 40% after plan deductible</p>
<p><b>Men's Family Planning Services</b></p> <p>Office Visits, Lab and Radiology Tests and Counseling</p> <p>Surgical Sterilization Procedures for Vasectomy (excludes reversals)</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p>	<p>You pay \$20 PCP or \$40 Specialist per office visit copay and plan deductible</p> <p>You pay \$20 PCP or \$40 Specialist per office visit copay and plan deductible</p> <p>You pay \$100 per admission copay, then plan deductible</p> <p>You pay \$100 per visit copay, then plan deductible</p>	<p>You pay 40% after plan deductible</p> <p>You pay 40% after plan deductible</p> <p>You pay \$300 per admission copay, then 40% after plan deductible</p> <p>You pay 40% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Infertility Treatment</b></p> <p>Services Not Covered include:</p> <ul style="list-style-type: none"> <li>• Testing performed specifically to determine the cause of infertility.</li> <li>• Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).</li> <li>• Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).</li> </ul> <p><b>Note:</b> Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.</p>	Not Covered	Not Covered
<p><b>Organ Transplants</b></p> <p>Includes all medically appropriate, non-experimental transplants</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Physician's Services</p> <p>Lifetime Travel Maximum: \$10,000 per transplant</p>	<p>You pay \$20 PCP or \$40 Specialist per office visit copay and plan deductible</p> <p>You pay \$100 per admission copay at Lifesource center, otherwise \$100 per admission copay and plan deductible</p> <p>No charge at Lifesource center, otherwise you pay plan deductible</p> <p>No charge (only available when using Lifesource facility)</p>	<p>In-Network coverage only</p> <p>In-Network coverage only</p> <p>In-Network coverage only</p> <p>In-Network coverage only</p>
<p><b>Durable Medical Equipment</b></p> <p>Calendar Year Maximum: Unlimited</p>	You pay plan deductible	In-Network coverage only
<p><b>Breast Feeding Equipment and Supplies</b></p> <p><b>Note:</b> Includes related supplies. Includes the rental or purchase of one (non-Hospital grade) breast pump per birth as ordered or prescribed by a physician. Includes related supplies.</p>	No charge	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>External Prosthetic Appliances</b> Calendar Year Maximum: Unlimited	You pay \$200 EPA copay per occurrence, then plan deductible	In-Network coverage only
<b>Nutritional Evaluation</b> Calendar Year Maximum: 3 visits per person  Physician's Office Visit  Inpatient Facility  Outpatient Facility	You pay \$20 PCP or \$40 Specialist per office visit copay and plan deductible  You pay \$100 per admission copay, then plan deductible  You pay \$100 per visit copay, then plan deductible	You pay 40% after plan deductible  You pay \$300 per admission copay, then 40% after plan deductible  You pay 40% after plan deductible
<b>Dental Care</b> Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.  Physician's Office Visit  Inpatient Facility  Outpatient Facility	You pay \$20 PCP or \$40 Specialist per office visit copay and plan deductible  \$100 per admission copay, then plan deductible  You pay \$100 per visit copay, then plan deductible	You pay 40% after plan deductible  You pay \$300 per admission copay, then 40% after plan deductible  You pay 40% after plan deductible
<b>TMJ Surgical and Non-Surgical</b> Always subject to medical necessity.  Physician's Office Visit  Inpatient Facility  Outpatient Facility	You pay \$20 PCP or \$40 Specialist per office visit copay and plan deductible  You pay \$100 per admission copay, then plan deductible  You pay \$100 per visit copay, then plan deductible	In-Network coverage only  In-Network coverage only  In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Bariatric Surgery</b></p> <p><b>Note:</b> Subject to any limitations shown in the “Exclusions, Expenses Not Covered and General Limitations” section of this certificate (see page 45).</p> <p>Physician’s Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p>	<p>No charge after the \$20 PCP or \$40 Specialist per office visit copay and plan deductible</p> <p>\$100 per admission copay, then 100% after plan deductible</p> <p>\$100 per visit copay, then 100% after plan deductible</p>	<p>In-Network coverage only</p> <p>In-Network coverage only</p> <p>In-Network coverage only</p>
<p><b>Hearing Aids</b> Maximum: \$5,000 every 3 calendar years</p>	<p>You pay plan deductible</p>	<p>In-Network coverage only</p>
<p><b>Routine Foot Disorders</b></p>	<p>Not covered except for services associated with foot care for diabetes and peripheral vascular disease.</p>	<p>Not covered</p>
<p><b>Treatment Resulting From Life Threatening Emergencies</b></p> <p>Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.</p>		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Mental Health</b></p> <p>Inpatient</p> <p>Outpatient (Includes Individual, Group and Intensive Outpatient)</p> <p>Physician's Office Visit</p> <p>Outpatient Facility</p>	<p>You pay \$100 per admission copay, then plan deductible</p> <p>You pay \$40 per visit copay , then plan deductible</p> <p>You pay \$40 per visit copay</p>	<p>You pay \$300 per admission copay, then 40% after plan deductible</p> <p>You pay 40% after plan deductible</p> <p>You pay 40% after plan deductible</p>
<p><b>Autism Spectrum Disorder</b></p> <p>The Autism Spectrum Disorders (ASD) are a range of complex behavioral disorders that can cause serious, lifelong impairments in behavior, cognition, and social development. Autism Spectrum Disorders are also referred to as pervasive developmental disorders (PDD), and include the following:</p> <ul style="list-style-type: none"> <li>• Autism or autistic disorder</li> <li>• Asperser's syndrome</li> <li>• Pervasive developmental disorder</li> <li>• Childhood disintegrative disorder (Heller's syndrome)</li> <li>• Rett's disorder</li> </ul> <p>Office visits, labs and imagining to rule out other underlying conditions - Covered same as any other illness (subject to applicable copay, deductible, coinsurance, etc.)</p> <p>Speech therapy, occupational therapy, physical therapy to treat autism - Covered same as any other illness (subject to applicable copay, deductible, coinsurance, etc.)</p> <p>Psychotherapy to manage behavioral issues related to autism - Covered same as any other illness (subject to applicable copay, deductible, coinsurance, etc.)</p> <p>ABA therapy and other early intensive behavioral interventions - <b>Not Covered</b></p>		
<p><b>Substance Abuse</b></p> <p>Inpatient</p> <p>Outpatient (Includes Individual and Intensive Outpatient)</p> <p>Physician's Office Visit</p> <p>Outpatient Facility</p>	<p>You pay \$100 per admission copay, then plan deductible</p> <p>You pay \$40 per visit copay , then plan deductible</p> <p>You pay \$40 per visit copay</p>	<p>You pay \$300 per admission copay, then 40% after plan deductible</p> <p>You pay 40% after plan deductible</p> <p>You pay 40% after plan deductible</p>

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## City of Memphis Basic Plan Benefits

### The Schedule

#### For You and Your Dependents

City of Memphis Basic Plan Benefits provide coverage for care In-Network and Out-of-Network. To receive City of Memphis Basic Plan Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

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

#### Coinsurance

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

#### Copayments/Deductibles

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

#### Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%:

- Coinsurance.

Once the Out-of-Pocket Maximum is reached for covered services that apply to the Out-of-Pocket Maximum, any copayments and/or benefit deductibles are no longer required.

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Non-compliance penalties.
- Plan Deductible.
- Any copayments and/or benefit deductibles.
- Provider charges in excess of the Maximum Reimbursable Charge.

#### Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums do not cross-accumulate (that is, In-Network will accumulate to In-Network and Out-of-Network will accumulate to Out-of-Network). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.

#### Multiple Surgical Reduction

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

## City of Memphis Basic Plan Benefits

### The Schedule

#### Assistant Surgeon and Co-Surgeon Charges

##### Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

##### Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Lifetime Maximum</b>	Unlimited	
<b>Coinsurance Level</b>  <b>Note:</b> "No charge" means an insured person is not required to pay Coinsurance.	The plan pays 90%  You pay 10%	The plan pays 70% of the Maximum Reimbursable Charge.  You pay 30% plus any additional amount billed by the provider in excess of the Maximum Reimbursable Charge.
<b>Calendar Year Deductible</b>  Individual Family Maximum  Note: The plan deductible is waived for members when this plan is secondary for the purposes of coordination Family Maximum Calculation <b>Individual Calculation:</b> Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.	\$350 per person  \$1,050 per family	\$350 per person  \$1,050 per family

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Out-of-Pocket Maximum</b></p> <p>Individual Family Maximum Family Maximum Calculation</p> <p><b>Individual Calculation:</b> Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.</p>	<p>\$1,500 per person \$3,000 per family</p>	<p>\$3,500 per person \$7,000 per family</p>
<p><b>Physician's Services</b></p> <p>Primary Care Physician's Office Visit Specialty Care Physician's Office Visits     Consultant and Referral Physician's Services</p> <p>Surgery Performed in the Physician's Office Second Opinion Consultations (provided on a voluntary basis) Allergy Treatment/Injections Allergy Serum (dispensed by the Physician in the office)</p>	<p>You pay 10% after plan deductible You pay 10% after plan deductible  You pay 10% after plan deductible You pay 10% after plan deductible No charge No charge</p>	<p>You pay 30% after plan deductible You pay 30% after plan deductible  You pay 30% after plan deductible You pay 30% after plan deductible You pay 30% after plan deductible You pay 30% after plan deductible</p>
<p><b>Preventive Care</b></p> <p>Note: for Vision exam, see page 43 for details.</p> <p><b>Note:</b> Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.</p> <p>Routine Preventive Care - all ages Immunizations - all ages</p>	<p>No charge No charge</p>	<p>In-Network coverage only In-Network coverage only</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Mammograms, PSA, PAP Smear</b> Preventive Care Related Services (i.e. "routine" services) Diagnostic Related Services (i.e. "non-routine" services)	No charge  You pay 10% after plan deductible	In-Network coverage only  You pay 30% after plan deductible
<b>Inpatient Hospital - Facility Services</b>  Semi-Private Room and Board  Private Room  Special Care Units (ICU/CCU)	You pay \$100 per admission copay, then 10% after plan deductible  Limited to the semi-private room negotiated rate  Limited to the semi-private room negotiated rate  Limited to the negotiated rate	You pay \$300 per admission copay, then 30% after plan deductible  Limited to the semi-private room rate  Limited to the semi-private room rate  Limited to the ICU/CCU daily room rate
<b>Outpatient Facility Services</b> Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	You pay 10% after plan deductible	You pay 30% after plan deductible
<b>Outpatient Therapeutic Treatments</b> Includes dialysis, intravenous chemotherapy and other infusion therapies	You pay 10% after plan deductible	You pay 30% after plan deductible
<b>Inpatient Hospital Physician's Visits/Consultations</b>	You pay 10% after plan deductible	You pay 30% after plan deductible
<b>Inpatient Hospital Professional Services</b> Surgeon Radiologist Pathologist Anesthesiologist	You pay 10% after plan deductible	You pay 30% after plan deductible
<b>Outpatient Professional Services</b> Surgeon Radiologist Pathologist Anesthesiologist	You pay 10% after plan deductible	You pay 30% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Emergency and Urgent Care Services</b></p> <p>Hospital Emergency Room</p> <p>Urgent Care Facility or Outpatient Facility</p> <p>X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)</p> <p>Independent x-ray and/or Lab Facility in conjunction with an ER visit</p> <p>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)</p>	<p>You pay 10% after \$100 per visit copay* and plan deductible</p> <p>*waived if admitted</p> <p>You pay 10% after plan deductible</p>	<p>You pay 10% after \$100 per visit copay* and plan deductible</p> <p>*waived if admitted</p> <p>You pay 10% after plan deductible</p>
<p><b>Ambulance</b>  <b>Note:</b> Emergency transportation by ground or air. Non-Emergency transportation requires prior-authorization.</p>	<p>You pay 10% after plan deductible</p>	<p>You pay 10% after plan deductible</p>
<p><b>Inpatient Services at Other Health Care Facilities</b></p> <p>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</p> <p>Calendar Year Maximum: 70 days combined</p>	<p>You pay 10% after plan deductible</p>	<p>You pay 30% after plan deductible</p>
<p><b>Laboratory and Radiology Services (includes pre-admission testing)</b></p> <p>Physician's Office Visit</p> <p>Outpatient Hospital Facility</p> <p>Independent X-ray and/or Lab Facility</p>	<p>You pay 10% after plan deductible</p> <p>You pay 10% after plan deductible</p> <p>You pay 10% after plan deductible</p>	<p>You pay 30% after plan deductible</p> <p>You pay 30% after plan deductible</p> <p>You pay 30% after plan deductible</p>
<p><b>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</b></p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p>	<p>You pay 10% after plan deductible</p> <p>You pay \$100 per admission copay, then 10% after plan deductible</p> <p>You pay 10% after plan deductible</p>	<p>You pay 30% after plan deductible</p> <p>You pay \$300 per admission copay, then 30% after plan deductible</p> <p>You pay 30% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Outpatient Short-Term Rehabilitative Therapy</b></p> <p>Calendar Year Maximum: 60 days for all therapies combined</p> <p>Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy</p>	You pay 10% after plan deductible	In-Network coverage only
<p><b>Outpatient Cardiac Rehabilitation</b></p> <p>Calendar Year Maximum: 36 days</p>	You pay 10% after plan deductible	In-Network coverage only
<p><b>Chiropractic Care</b></p> <p>Calendar Year Maximum: 20 days</p> <p>Physician's Office Visit</p>	You pay 10% after plan deductible	In-Network coverage only
<p><b>Home Health Care</b></p> <p>Calendar Year Maximum: Unlimited (includes outpatient nursing when approved as medically necessary)</p>	You pay 10% after plan deductible	You pay 30% after plan deductible
<p><b>Hospice</b></p> <p>Inpatient Services</p> <p>Outpatient Services (same coinsurance level as Home Health Care)</p>	<p>You pay 10% after plan deductible</p> <p>You pay 10% after plan deductible</p>	<p>You pay 30% after plan deductible</p> <p>You pay 30% after plan deductible</p>
<p><b>Bereavement Counseling</b></p> <p>Services provided as part of Hospice Care</p> <p>Inpatient</p> <p>Outpatient</p> <p>Services provided by Mental Health Professional</p>	<p>You pay 10% after plan deductible</p> <p>You pay 10% after plan deductible</p> <p>Covered under Mental Health Benefit</p>	<p>You pay 30% after plan deductible</p> <p>You pay 30% after plan deductible</p> <p>Covered under Mental Health Benefit</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Maternity Care Services</b>  <b>Note:</b> Plan does not cover maternity care for pregnant dependent children. Benefit only available for pregnant Employee or Dependent Spouse.</p> <p>Initial Visit to Confirm Pregnancy</p> <p>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)</p> <p>Delivery - Facility (Inpatient Hospital, Birthing Center)</p>	<p>You pay 10% after plan deductible</p> <p>You pay 10% after plan deductible</p> <p>You pay \$100 per admission copay, then 10% after plan deductible</p>	<p>You pay 30% after plan deductible</p> <p>You pay 30% after plan deductible</p> <p>You pay \$300 per admission copay, then 30% after plan deductible</p>
<p><b>Women's Family Planning Services</b></p> <p>Office Visits, Lab and Radiology Tests and Counseling</p> <p><b>Note:</b> Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.</p> <p>Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>You pay 30% after plan deductible</p> <p>You pay 30% after plan deductible</p> <p>You pay \$300 per admission copay, then 30% after plan deductible</p> <p>You pay 30% after plan deductible</p>
<p><b>Men's Family Planning Services</b></p> <p>Office Visits, Lab and Radiology Tests and Counseling</p> <p>Surgical Sterilization Procedures for Vasectomy (excludes reversals)</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p>	<p>You pay 10% after plan deductible</p> <p>You pay 10% after plan deductible</p> <p>You pay 10% after plan deductible</p> <p>You pay \$100 per admission copay, then 10% after plan deductible</p> <p>You pay 10% after plan deductible</p>	<p>You pay 30% after plan deductible</p> <p>You pay 30% after plan deductible</p> <p>You pay 30% after plan deductible</p> <p>You pay \$300 per admission copay, then 30% after plan deductible</p> <p>You pay 30% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Infertility Treatment</b></p> <p>Services Not Covered include:</p> <ul style="list-style-type: none"> <li>• Testing performed specifically to determine the cause of infertility.</li> <li>• Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).</li> <li>• Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).</li> </ul> <p><b>Note:</b> Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.</p>	Not Covered	Not Covered
<p><b>Organ Transplants</b></p> <p>Includes all medically appropriate, non-experimental transplants</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Physician's Services</p> <p>Lifetime Travel Maximum: \$10,000 per transplant</p>	<p>You pay 10% after plan deductible</p> <p>You pay \$100 per admission copay at Lifesource center, otherwise 10% after \$100 per admission copay and plan deductible</p> <p>No charge at Lifesource center, otherwise you pay 10% after plan deductible</p> <p>No charge (only available when using Lifesource facility)</p>	<p>In-Network coverage only</p> <p>In-Network coverage only</p> <p>In-Network coverage only</p> <p>In-Network coverage only</p>
<p><b>Durable Medical Equipment</b></p> <p>Calendar Year Maximum: Unlimited</p>	You pay 10% after plan deductible	You pay 30% after plan deductible
<p><b>Breast Feeding Equipment and Supplies</b></p> <p><b>Note:</b> Includes the rental or purchase of one (non-Hospital grade) breast pump per birth as ordered or prescribed by a physician. Includes related supplies.</p>	No charge	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>External Prosthetic Appliances</b> Calendar Year Maximum: Unlimited	You pay 10% after plan deductible	You pay 30% after plan deductible
<b>Nutritional Evaluation</b> Calendar Year Maximum: 3 visits per person Physician's Office Visit Inpatient Facility Outpatient Facility	You pay 10% after plan deductible You pay \$100 per admission copay, then 10% after plan deductible You pay 10% after plan deductible	You pay 30% after plan deductible You pay \$300 per admission copay, then 30% after plan deductible You pay 30% after plan deductible
<b>Dental Care</b> Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth. Physician's Office Visit Inpatient Facility Outpatient Facility	You pay 10% after plan deductible You pay \$100 per admission copay, then 10% after plan deductible You pay 10% after plan deductible	You pay 30% after plan deductible You pay \$300 per admission copay, then 30% after plan deductible You pay 30% after plan deductible
<b>TMJ Surgical and Non-Surgical</b> Always subject to medical necessity. Physician's Office Visit Inpatient Facility Outpatient Facility	You pay 10% after plan deductible You pay \$100 per admission copay, then 10% after plan deductible You pay 10% after plan deductible	In-Network coverage only In-Network coverage only In-Network coverage only
<b>Bariatric Surgery</b> <b>Note:</b> Subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate (see page 45). Physician's Office Visit Inpatient Facility Outpatient Facility	You pay 10% after plan deductible You pay \$100 per admission copay, then 10% after plan deductible You pay 10% after plan deductible	In-Network coverage only In-Network coverage only In-Network coverage only
<b>Hearing Aids</b> Maximum: \$5,000 every 3 calendar years	You pay 10% after plan deductible	You pay 30% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Routine Foot Disorders</b>	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.	Not covered
<p><b>Treatment Resulting From Life Threatening Emergencies</b></p> <p>Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.</p>		
<p><b>Mental Health</b></p> <p>Inpatient</p> <p>Outpatient (Includes Individual, Group and Intensive Outpatient)</p> <p>Physician's Office Visit</p> <p>Outpatient Facility</p>	<p>You pay \$100 per admission copay, then 10% after plan deductible</p> <p>You pay 10% after plan deductible</p> <p>You pay 10% after plan deductible</p>	<p>You pay \$300 per admission copay, then 30% after plan deductible</p> <p>You pay 30% after plan deductible</p> <p>You pay 30% after plan deductible</p>
<p><b>Autism Spectrum Disorder</b></p> <p>The Autism Spectrum Disorders (ASD) are a range of complex behavioral disorders that can cause serious, lifelong impairments in behavior, cognition, and social development. Autism Spectrum Disorders are also referred to as pervasive developmental disorders (PDD), and include the following:</p> <ul style="list-style-type: none"> <li>• Autism or autistic disorder</li> <li>• Asperser's syndrome</li> <li>• Pervasive developmental disorder</li> <li>• Childhood disintegrative disorder (Heller's syndrome)</li> <li>• Rett's disorder</li> </ul> <p>Office visits, labs and imagining to rule out other underlying conditions - Covered same as any other illness (subject to applicable copay, deductible, coinsurance, etc.)</p> <p>Speech therapy, occupational therapy, physical therapy to treat autism - Covered same as any other illness (subject to applicable copay, deductible, coinsurance, etc.)</p> <p>Psychotherapy to manage behavioral issues related to autism - Covered same as any other illness (subject to applicable copay, deductible, coinsurance, etc.)</p> <p>ABA therapy and other early intensive behavioral interventions - <b>Not Covered</b></p>		
<p><b>Substance Abuse</b></p> <p>Inpatient</p> <p>Outpatient (Includes Individual and Intensive Outpatient)</p> <p>Physician's Office Visit</p> <p>Outpatient Facility</p>	<p>You pay \$100 per admission copay, then 10% after plan deductible</p> <p>You pay 10% after plan deductible</p> <p>You pay 10% after plan deductible</p>	<p>You pay \$300 per admission copay, then 30% after plan deductible</p> <p>You pay 30% after plan deductible</p> <p>You pay 30% after plan deductible</p>

## City of Memphis Basic and Premier Plan Medical Benefits

### Certification Requirements - Out-of- Network

#### For You and Your Dependents

#### Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

- as a registered bed patient;
- 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 PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will not include the first \$500 and will be reduced by 50% for Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

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

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

HC-PAC1

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#### \*Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- non-emergency ambulance; or
- transplant services.

#### \* SPECIAL NOTE REGARDING MEDICARE

- If you are enrolled in Medicare on a primary basis (Medicare pays before we pay benefits under the plan), the notification requirements described in this SPD do not apply to you. You are not required to notify the claims administrator before receiving covered health services.

HC-PRA1

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#### Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

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### Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for a mammogram for women ages 35 to 69, every one to two years, or at any age for women at risk, when recommended by a Physician.
- charges made for an annual Papanicolaou laboratory screening test.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical

services connected with surgical therapies (tubal ligations, vasectomies).

- abortion when a Physician certifies in writing that the pregnancy would endanger the life of the mother, or when the expenses are incurred to treat medical complications due to abortion.
- charges made for the following preventive care services (detailed information is available at [www.healthcare.gov/center/regulations/prevention/recommendations.html](http://www.healthcare.gov/center/regulations/prevention/recommendations.html)):
  - (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
  - (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
  - (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
  - (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- charges made for surgical or nonsurgical treatment of Temporomandibular Joint Dysfunction.
- charges made for 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.

### Clinical Trials

Charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:

- the cancer clinical trial is listed on the NIH web site [www.clinicaltrials.gov](http://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 participant.

### **Genetic Testing**

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

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

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing.

### **Nutritional Evaluation**

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

### **Enteral Formula**

- charges made for home enteral nutritional formula as medically necessary when the formula is the primary source of nutrition (i.e., 60% or more of caloric nutritional intake) and all of the following criteria are met:
- Without enteral feedings, the individual would be unable to obtain sufficient nutrients to maintain an appropriate

weight by dietary adjustment and/or oral supplements.

- The individual has one of the following conditions that is expected to be permanent or of indefinite duration:
- an anatomical or mobility disorder of the gastrointestinal tract that prevents food from reaching the small bowel.
- disease of the small bowel that impairs absorption of an oral diet.
- a central nervous system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.

### **Internal Prosthetic/Medical Appliances**

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

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### **Orthognathic Surgery**

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

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

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### **Cardiac Rehabilitation**

- Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based

outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

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### Home Health Services

- charges made for Home Health Services when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility.

Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

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### Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;
  - physical, occupational and speech therapy;
  - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and

laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

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

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living.

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### **Mental Health and Substance Abuse Services**

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

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

### **Inpatient Mental Health Services**

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

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

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the

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

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

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

### **Outpatient Mental Health Services**

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

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

### **Inpatient Substance Abuse Rehabilitation Services**

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions and Residential Treatment services.

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

**Substance Abuse Residential Treatment Services** are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

**Substance Abuse Residential Treatment Center** means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

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

#### **Outpatient Substance Abuse Rehabilitation Services**

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

#### **Substance Abuse Detoxification Services**

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

#### **Exclusions**

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

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

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#### **Durable Medical Equipment**

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

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.

Durable Medical Equipment also includes coverage for Braces. A Brace is defined as an orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part. The following braces are specifically excluded: Copes scoliosis braces. A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts and is covered under Durable Medical Equipment.

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

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches,

bath stools, hand held showers, paraffin baths, bath mats, and spas.

- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

#### **Orthoses and Orthotic Devices**

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

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

The following are specifically excluded orthoses and orthotic devices:

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

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#### **External Prosthetic Appliances and Devices**

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

#### **Prostheses/Prosthetic Appliances and Devices**

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

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

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

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

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

The following are specifically excluded external prosthetic appliances and devices:

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

### Short-Term Rehabilitative Therapy

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

The following limitation applies 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.

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

### Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic

treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment 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 Care Services:

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

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor 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.

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### Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

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### Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

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### Transplant Services

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

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

All Transplant services, other than cornea, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities.

Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are 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 are also 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 will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses: travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

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

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## City of Memphis VISION EXAM

### The Schedule For You and Your Dependents

**Benefits Include:**

- Examinations – One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
	The Plan will pay 100%	Not Covered
<b>Examinations</b> One Eye Exam every Calendar Year	100%	Not Covered
<b>Eye Glasses/Contact Lenses/Frames</b>	Not Covered	Not Covered

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## City of Memphis Vision Exam

### Covered Expenses

The Schedule of Vision Benefits that accompanies your certificate booklet lists covered services.

Cigna will pay for covered services incurred by you and your eligible Dependents, for one vision examination per calendar year, including but not limited to eye health examination, dilation, refraction and prescription for contacts or glasses. This benefit does not include any other services or hardware (glasses, lenses, frames, contacts, etc.).

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### Vision Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- Any eyeglasses, lenses, frames or contact lenses.
- Orthoptic or vision training and any associated supplemental testing.
- Prescription sunglasses.
- Medical or surgical treatment of the eyes (see Schedule of Medical Benefits).
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Magnification or low vision aids.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment.
- For or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related.

Other Limitations are shown in the Exclusions, Expenses Not Covered and General Limitations section.

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## **Exclusions, Expenses Not Covered and General Limitations**

### **Exclusions and Expenses Not Covered**

**Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:**

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared, 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.
- for or in connection with experimental, investigational or unproven services.

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

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or 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 "Clinical Trials" section of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.
- 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: Abdominoplasty; Panniculectomy; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- The following services are excluded from coverage unless they are demonstrated to be medically necessary: Rhinoplasty and Blepharoplasty.
- 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 other than for treatment of TMJ disorder. 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.
- for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung, and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:
  - medical and surgical services to alter appearances 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, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is 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

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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.

- reversal of male or female voluntary sterilization procedures.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, for treatment of erectile dysfunction. However penile implants are covered when an established medical condition is the cause of erectile dysfunction.
- 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 to 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, 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 Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing.
- 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, dentures and wigs.

- 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).
- eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- treatment by acupuncture.
- 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.
- 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 or plasma when a refund or credit is made for those items.
- 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.
- for or in connection with an Injury or Sickness arising out of, or related to an On the Job Injury.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.
- abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.

- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
- Oral appliances for snoring.
- Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
- Any charge for services, supplies or equipment advertised by the provider as free.
- Any charges prohibited by federal anti-kickback or self-referral statutes.
- Injury or illness resulting from taking part in the commission of an assault or felony or being engaged in an illegal occupation.
- for or in connection with the pregnancy of a Dependent child, other than Complications of Pregnancy.

### **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 charges 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.

- expenses incurred outside the United States other than expenses for medically necessary urgent or emergent care while temporarily traveling abroad.

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### **Pre-existing Condition Limitations**

#### **Not applicable to anyone under age 19**

No payment will be made for Covered Expenses for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

#### **Pre-existing Condition**

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person begins an eligibility waiting period, or becomes insured for these benefits.

#### **Exceptions to Pre-existing Condition Limitation**

Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Preexisting Condition limitation if such child was covered within 60 days of birth, adoption or placement for adoption. Such waiver will not apply if 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

#### **Credit for Coverage Under Prior Plan**

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

Cigna will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy.

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### **Coordination of Benefits**

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

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**NOTE: ONLY THE CITY OF MEMPHIS DEDUCTIBLE IS WAIVED WHEN THE CITY OF MEMPHIS PLAN IS SECONDARY. THIS DOES NOT INCLUDE THE CITY OF MEMPHIS PLAN COPAYMENT NOR DOES IT INCLUDE MEDICARE'S DEDUCTIBLE(S).**

**Definitions**

For the purposes of this section, the following terms have the meanings set forth below:

**Plan**

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

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

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

**Closed Panel Plan**

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

**Primary Plan**

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

**Secondary Plan**

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

**Allowable Expense**

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

**Claim Determination Period**

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

**Reasonable Cash Value**

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

**Order of Benefit Determination Rules**

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan

which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

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

#### **Effect on the Benefits of This Plan**

When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all

Coverage Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. The difference between the primary plan payment and what the secondary coverage plan would have paid had it been primary is calculated to determine the secondary payment. As each claim is submitted, this Coverage Plan will:

1. Determine its obligation to pay or provide benefits under its Contract.
2. Determine whether there are any unpaid Allowable Expenses for the claim.
3. Determine the amount to be paid.

If the balance on the claim is equal to or less than what would have been paid if the City of Memphis plan was primary, the balance on the claim is paid in full. However, if the balance on the claim is greater than what the City of Memphis Plan would have paid if primary, the participant is responsible for the difference.

**NOTE: Benefits payable under this plan will never exceed the amount which would have been paid if there were no other plans involved.**

#### **Recovery of Excess Benefits**

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

#### **Right to Receive and Release Information**

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

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## Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

### Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

### Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;

- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

### Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

- By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

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## Payment of Benefits

### To Whom Payable

Medical and Vision Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

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

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

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

### Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

### Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology,

- the methodologies as reported by generally recognized professionals or publications.

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## When Coverage Ends

This section provides you with information about all of the following:

- Events that cause coverage to end.
- The date your coverage ends.
- Extended coverage.
- Continuation of coverage under federal law (COBRA).

### General Information about When Coverage Ends

We may discontinue this benefit Plan and/or all similar benefit plans at any time.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred after your coverage ended, even if the underlying medical condition occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Participant's coverage ends or the date the dependent ceases to be eligible as defined by the plan.

## Events Ending Your Coverage

Coverage ends on the 15th or last day of the month, based on contributions paid, when any of the following occurs:

### The Entire Plan Ends

Your coverage ends on the date the Plan ends. City of Memphis is responsible for notifying you that your coverage has ended.

### Your employer no longer covered

Your employer ceases to be an associated company of the plan sponsor

### You Are No Longer Eligible

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Your coverage ends on the date you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to the section called "Definitions" for a more complete definition of the terms "Eligible Person", "Participant", "Dependent" and "Enrolled Dependent".

#### **The Claims Administrator Receives Notice to End Coverage**

Your coverage ends on the date the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.

#### **Other Events Ending Your Coverage**

When any of the following happen, we will provide written notice to the Participant that coverage has ended on the date the Plan Administrator identifies in the notice:

##### **Fraud, Misrepresentation or False Information**

Fraud or misrepresentation, or because the Participant knowingly gave us or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent. During the first two years the Plan is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

##### **Material Violation**

There was a material violation of the terms of the Plan.

##### **Improper Use of ID Card**

You permitted an unauthorized person to use your ID card, or you used another person's card.

##### **Failure to Pay**

You failed to pay a required contribution.

##### **Threatening Behavior**

You committed acts of physical or verbal abuse that pose a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.

**If you are covered as an active employee and stop active work on a full-time basis, coverage will not end:**

a) if you stop active work due to injury, illness or qualified leave of absence for personal injury or illness, your employer will continue your medical coverage subject to payment of contributions and guidelines set forth in the City of Memphis Personnel Manual and the policies and procedures in the Benefits Office.

b) if you stop active work to take a qualified military leave of absence (pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994) you may elect to continue coverage subject to payment of contributions and guidelines set forth in the City of Memphis Personnel Manual and the policies and procedures in the Benefits Office.

c) if you stop active work to take a qualified leave of absence (pursuant to the Family and Medical Leave Act of 1993 or other applicable state's leave law, if any such law applies to your employer), for reasons other than personal illness or injury, your employer will continue coverage subject to payment of contributions and guidelines set forth in the City of Memphis Personnel Manual and the policies and procedures in the Benefits Office.

d) if you stop active work due to other leaves of absence, your employer may elect to continue coverage subject to payment of contributions and guidelines set forth in the City of Memphis Personnel Manual and the policies and procedures in the Benefits Office.

#### **Coverage for a Handicapped Child**

Coverage for an Enrolled Dependent child who has never been married and who is not able to be self-supporting because of mental retardation or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental retardation or physical handicap.

- Depends mainly on the Participant for support.

Coverage will continue as long as the Enrolled Dependent remains unmarried, incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan. We will ask you to furnish the Plan Administrator with proof of the child's incapacity and dependency within 60 days of the date coverage would otherwise have ended because the child reached a certain age. The Plan Administrator may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. However, we will not ask for this information more than once a year. If you do not provide proof of the child's incapacity and dependency within 60 days of the Plan Administrator's request as described above, coverage for that child will end.

## **Rescissions**

Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

## **General Legal Provisions**

The Summary Plan Description presents an overview of your Benefits. We and the claims administrator have sole and exclusive discretion to Interpret Benefits under the Plan; Interpret the other terms, conditions, limitations and exclusions of the Plan, including the SPD and any Riders and Amendments; Make factual determinations related to the Plan and its Benefits.

We and the Claims Administrator may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

### **Administrative Services**

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

### **Amendments to the Plan**

We reserve the right, in our sole discretion and without your approval to change interpret, modify, withdraw or add Benefits or terminate the Plan. Plan Amendments and Riders are effective on the date we specify.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or

regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in written resolution (in the case of a termination), whether prospective or retrospective or retroactive, to the Plan, in accordance with the procedures established by us. Covered Persons will receive notice of any material modification to the Plan.

No one has the authority to make any oral modification to the SPD.

### **Clerical Error**

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this SPD.

### **Information and Records**

At times we or the Claims Administrator may need additional information from you. You agree to furnish us and/or the Claims Administrator with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it, we may delay or deny payment of your Benefits.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us or the Claims Administrator with all information or copies of records relating to the services provided to you. We or the Claims Administrator have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Participant's enrollment form. We and the Claims Administrator agree that such information and records will be considered confidential.

We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover

their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we or the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan Administrator.

### **Examination of Covered Persons**

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

### **On the Job Injury (OJI)/Worker's Compensation not Affected**

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

### **Relationship with Providers**

The relationships between us, the Claims Administrator, and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Nor are they agents or employees of the Claims Administrator. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits. Network providers are independent practitioners who run their own office and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. Network providers are not our employees or employees of the Claims Administrator; nor do we have any other relationship with Network providers such as principal-agent or joint venture. Neither we nor the Claims Administrator are liable for any act or omission of any provider.

The Claims Administrator is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under the Plan.

We and the Claim Administrator are solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits
- Notifying you of the termination or modifications to the Plan.

### **Your Relationship with Providers**

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and us is that of employer and employee, Dependent or other classification as defined in the Plan.

### **Limitation of Action**

If you want to bring a legal action against us or the Claims Administrator you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted, or you lose any rights to bring such an action against us or the Claims Administrator.

You cannot bring any legal action against us or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring legal action against us or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal, or you lose any rights to bring such an action against us or the Claims Administrator.

HC-TRM80

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### **Federal Requirements**

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

HC-FED1

10-10

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## **Notice of Provider Directory/Networks**

### **Notice Regarding Provider Directories and Provider Networks**

If your Plan uses a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge by visiting [www.cigna.com](http://www.cigna.com); [mycigna.com](http://mycigna.com) or by calling the toll-free telephone number on your ID card.

Your Participating Provider network consists of a group of local medical practitioners, including Hospitals, of varied specialties as well as general practice, who are employed by or contracted with Cigna HealthCare.

HC-FED2

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## **Qualified Medical Child Support Order (QMCSO)**

### **Eligibility for Coverage Under a QMCSO**

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

### **Qualified Medical Child Support Order Defined**

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

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and

- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

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

### **Payment of Benefits**

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child. No expenses will be reimbursed prior to the effective date of coverage for the child

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

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

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.

- **Loss of eligibility for State Medicaid or Children’s Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan’s network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee’s or Dependent’s other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the employer or other responsible entity to remit

premiums on a timely basis; when the person no longer resides or works in the other plan’s service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer’s limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

- **Eligibility for employment assistance under State Medicaid or Children’s Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

**Except as stated above, special enrollment must be requested within 60 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption if enrollment is completed within 60 days of the event. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.**

Individuals who enroll in the Plan due to a special enrollment event will not be considered Late Entrants. Any Pre-existing Condition limitation will be applied upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

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### **Effect of Section 125 Tax Regulations on This Plan**

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

#### **A. Coverage Elections**

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

agrees and you enroll for or change coverage within 60 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through E.

#### **B. Change of Status**

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

#### **C. Court Order**

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

#### **D. Medicare or Medicaid Eligibility/Entitlement**

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

#### **E. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan**

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

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### **Eligibility for Coverage for Adopted Children**

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Dependent Insurance" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED8

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### **Coverage for Maternity Hospital Stay**

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

HC-FED10

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## **Women’s Health and Cancer Rights Act (WHCRA)**

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

HC-FED12

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## **Pre-Existing Conditions Under the Health Insurance Portability & Accountability Act (HIPAA)**

### **Not Applicable to Anyone Under 19**

A federal law known as the Health Insurance Portability & Accountability Act (HIPAA) establishes requirements for Pre-existing Condition limitation provisions in health plans. Following is an explanation of the requirements and limitations under this law.

### **Pre-Existing Condition Limitation**

Under HIPAA, a Pre-existing Condition limitation is a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under the plan, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. A Pre-existing Condition limitation is permitted under group health plans, provided it is applied only to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period (or a shorter period as applies under the plan) ending on the enrollment date. Plan provisions may vary. Please refer to the section entitled “Exclusions, Expenses Not Covered and General Limitations” for the specific Pre-existing Condition limitation provision which applies under this Plan, if any.

### **Exceptions to Pre-existing Condition Limitation**

Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

An adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered under any Creditable Coverage within 30 days of adoption or placement for adoption. Such waiver will not apply if 63 days or more elapse between coverage under the prior Creditable Coverage and coverage under this Plan.

## **Credit for Coverage Under Prior Plan**

If you and/or your Dependent(s) were previously covered under a plan which qualifies as Creditable Coverage, Cigna will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under the prior plan(s). However, credit is available only if you notify the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this Plan, exclusive of any waiting period. Credit will be given for coverage under all prior Creditable Coverage, provided fewer than 63 days elapsed between coverage under any two plans.

If you and/or your Dependent enrolled or re-enrolled in COBRA continuation coverage or state continuation coverage under the extended election period allowed in the American Recovery and Reinvestment Act of 2009 (“ARRA”), this lapse in coverage will be disregarded for the purposes of determining Creditable Coverage.

### **Certificate of Prior Creditable Coverage**

You must provide proof of your prior Creditable Coverage in order to reduce a Pre-Existing Condition limitation period. You should submit proof of prior coverage with your enrollment material. A certificate of prior Creditable Coverage, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent directly to: City of Memphis Health Wellness and Benefits. You should contact the Plan Administrator or a Cigna Customer Service Representative if assistance is needed to obtain proof of prior Creditable Coverage. Once your prior coverage records are reviewed and credit is calculated, you will receive a notice of any remaining Pre-existing Condition limitation period.

### **Creditable Coverage**

Creditable Coverage will include coverage under any of the following: A self-insured employer group health plan; Individual or group health insurance indemnity or HMO plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; A health plan for certain members of the uniformed armed services and their dependents, including the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service; A medical care program of the Indian Health Service or of a tribal organization; A state health benefits risk pool; The Federal Employees Health Benefits Program; A public health plan established by a State, the U.S. government, or a foreign country; the Peace Corps Act; Or a State Children’s Health Insurance Program.

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## **Obtaining a Certificate of Creditable Coverage Under This Plan**

### **Applicable to All Enrollees Regardless of Age**

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact Cigna by calling 1-800-CIGNA24 or 1-800-244-6224.

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## **Requirements of Medical Leave Act of 1993 (as amended) (FMLA)**

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

### **Continuation of Health Insurance During Leave**

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid. You will remain responsible for your portion of the monthly premium.

### **Reinstatement of Canceled Insurance Following Leave**

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

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10-10M

## **Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)**

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents.

### **Continuation of Coverage**

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

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

### **Reinstatement of Benefits (applicable to all coverages)**

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-Existing Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

HC-FED18

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## **Claim Determination Procedures**

**The following complies with federal law. Provisions of the laws of your state may supersede.**

### **Procedures Regarding Medical Necessity Determinations**

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a “preservice medical necessity determination.” The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider’s network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider’s network participation documents, and in the determination notices.

### **Preservice Medical Necessity Determinations**

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

resume on the date you or your representative responds to the notice.

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

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

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

### **Concurrent Medical Necessity Determinations**

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

### **Postservice Medical Necessity Determinations**

When you or your representative requests a Medical Necessity determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna’s control Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what

information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

#### **Postservice Claim Determinations**

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

#### **Notice of Adverse Determination**

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

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### **Medical - When You Have a Complaint or an Appeal**

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf; unless otherwise noted.

"Physician Reviewers" are licensed Physicians depending on the care, service or treatment under review.

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

#### **Start With Member Services**

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

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

#### **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 or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

#### **Level-One Appeal**

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

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

#### **Level-Two Appeal**

If you are dissatisfied with our level-one appeal decision, you may request a second review. To initiate a level-two appeal, follow the same process required for a level-one 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.

For required preservice and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

#### **Independent Review Procedure**

If you are not fully satisfied with the decision of Cigna's level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare, or any of its affiliates. A decision to use the voluntary level of appeal will not affect 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 review denial. Cigna will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 30 days.

When requested and when a delay would be detrimental to your medical condition, as determined by Cigna's Physician reviewer, the review shall be completed within 3 days. The Independent Review Program is a voluntary program arranged by Cigna.

#### **Notice of Benefit Determination on Appeal**

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: 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; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

#### **Relevant Information**

Relevant information is any document, record or other information which: 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.

HC-FED38

04-12M

## **COBRA Continuation Rights Under Federal Law**

### **For You and Your Dependents**

#### **What is COBRA Continuation Coverage?**

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

#### **When is COBRA Continuation Available?**

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct, or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

#### **Who is Entitled to COBRA Continuation?**

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

#### **Secondary Qualifying Events**

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

#### **Disability Extension**

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA.

The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

#### **Medicare Extension for Your Dependents**

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

#### **Termination of COBRA Continuation**

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

#### **Moving Out of Employer's Service Area or Elimination of a Service Area**

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer's service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

#### **Employer's Notification Requirements**

Your Employer is required to provide you and/or your Dependents with the following notices (all notifications will come from the City of Memphis):

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

#### **How to Elect COBRA Continuation Coverage**

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA

continuation coverage in order for your Dependents to elect COBRA continuation.

#### **How Much Does COBRA Continuation Coverage Cost?**

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

#### **When and How to Pay COBRA Premiums**

Your Employer is required to provide you and/or your Dependents with the following notices (all notifications will come from the City of Memphis):

##### *First payment for COBRA continuation*

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

COBRA is administered by the City of Memphis and all payments should be made to the City of Memphis.

##### *Subsequent payments*

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

##### *Grace periods for subsequent payments*

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the

due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

#### **You Must Give Notice of Certain Qualifying Events**

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

#### **Newly Acquired Dependents**

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

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### **COBRA Continuation for Retirees Following Employer's Bankruptcy**

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

HC-FED37

04-12

### **Definitions**

#### **Active Service**

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1

04-10  
V1

#### **Bed and Board**

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

HC-DFS2

04-10  
V2

### **Charges**

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

HC-DFS3

04-10  
V1

### **Chiropractic Care**

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

HC-DFS55

04-10  
V1

### **Complications of Pregnancy - For Medical Insurance**

Expenses will be considered to be incurred for Complications of Pregnancy if they are incurred for: (a) an extrauterine pregnancy; (b) a pregnancy which ends by Caesarean section or miscarriage (other than elective abortion); or (c) a Sickness resulting from pregnancy.

DFS19

### **Custodial Services**

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

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self administered, and

- Services not required to be performed by trained or skilled medical or paramedical personnel.

HC-DFS4

04-10  
V1

**Dependent**

Dependents are:

- your lawful spouse of the opposite sex; and
- any child of yours who is:
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

Proof of the child's condition and dependence must be submitted to the City of Memphis within 60 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the City of Memphis may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you including that child from the first day of placement in your home regardless of whether the adoption has become final. It also includes a stepchild who lives with you, or a child for whom you are the legal guardian.

Benefits for a Dependent child will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.

Anyone who is covered as an Employee will not also be covered as a Dependent..

No one may be considered as a Dependent of more than one Employee.

HC-DFS414

04-10  
V1 M

**Emergency Services**

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include

uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

HC-DFS6

04-10  
V1

**Employee**

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term Employee is also deemed to mean an eligible Retiree of the Employer. The term does not include employees who are part-time or temporary.

HC-DFS7

04-10  
V3M

**Employer**

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf Cigna is providing claim administration services.

HC-DFS8

04-11  
V1

**Essential Health Benefits**

Essential health benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

HC-DFS411

01-11

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**Expense Incurred**

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

HC-DFS10

04-10  
V1

**Free-Standing Surgical Facility**

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

HC-DFS11

04-10  
V1

**Hospice Care Program**

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

HC-DFS51

04-10  
V1

**Hospice Care Services**

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility,

or any other licensed facility or agency under a Hospice Care Program.

HC-DFS52

04-10  
V1

**Hospice Facility**

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

HC-DFS53

04-10  
V1

**Hospital**

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an 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.

HC-DFS48

04-10  
V1

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**Hospital Confinement or Confined in a Hospital**

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance 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.

HC-DFS49

04-10  
V1

**Injury**

The term Injury means an accidental bodily injury.

HC-DFS12

04-10  
V1

**Maintenance Treatment**

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

HC-DFS56

04-10  
V1

**Maximum Reimbursable Charge - Medical**

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- a policyholder-selected percentage of a schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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 or for help determining the Maximum Reimbursable Charge for a specified service is available upon request by calling the toll-free number shown on your ID card.

HC-DFS13

04-10  
V4M

**Medicaid**

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

HC-DFS16

04-10  
V1

**Medically Necessary/Medical Necessity**

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.

HC-DFS19

04-10  
V1

**Medicare**

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

HC-DFS17

04-10  
V1

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**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 Hospital Confinement, 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; and any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

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

HC-DFS21

04-10  
V1**Nurse**

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

HC-DFS22

04-10  
V1**Ophthalmologist**

The term Ophthalmologist means a person practicing ophthalmology within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

HC-DFS70

04-10  
V1**Optician**

The term Optician means a fabricator and dispenser of eyeglasses and/or contact lenses. An optician fills prescriptions for glasses and other optical aids as specified by optometrists or ophthalmologists. The state in which an optician practices may or may not require licensure for rendering of these services.

HC-DFS71

04-10  
V1**Optometrist**

The term Optometrist means a person practicing optometry within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

HC-DFS72

04-10  
V1**Other Health Care Facility/Other Health Professional**

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS23

04-10  
V1**Participating Provider**

The term Participating Provider means 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.

HC-DFS45

04-10  
V1**Patient Protection and Affordable Care Act of 2010 ("PPACA")**

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

HC-DFS412

01-11

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**Physician**

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

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

HC-DFS25 04-10  
V1

**Preventive Treatment**

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

HC-DFS57 04-10  
V1

**Primary Care Physician**

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice 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.

HC-DFS40 04-10  
V1

**Psychologist**

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

HC-DFS26 04-10  
V1

**Review Organization**

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

HC-DFS30 04-10  
V1

**Sickness – For Medical Insurance**

The term Sickness means a physical or mental illness. It also includes pregnancy for you or your spouse and complications of pregnancy for your dependent child. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

HC-DFS50 04-10  
V1 M

**Skilled Nursing Facility**

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

HC-DFS31 04-10  
V1

**Specialist**

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

HC-DFS33 04-10  
V1

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**Terminal Illness**

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

HC-DFS54

04-10

V1

**Urgent Care**

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

HC-DFS34

04-10

V1

**Vision Provider**

The term Vision Provider means: an optometrist, ophthalmologist, optician or a group partnership or other legally recognized aggregation of such professionals; duly licensed and in good standing with the relevant public licensing bodies to provide covered vision services within the scope of the Vision Providers' respective licenses.

HC-DFS73

04-10

V1

## **Attachment I - Privacy**

### **Notice of Privacy Practices**

#### **Changes to this Notice**

The Plan reserves the right to change this Notice at any time and to make the revised or changed Notice effective for health information the Plan receives in the future. If the Plan changes its policies and practices, the Plan will revise this Notice and will provide a copy of the revised Notice to you within 60 days of the change. The Plan will post a copy of the current Notice on the City of Memphis Human Resources webpage.

#### **Filing a Complaint**

If you believe your privacy rights have been violated, you may file a written complaint with our Compliance Official at the address below.

**HIPAA Compliance Officer  
Human Resources Division  
2714 Union Avenue Extended 5<sup>th</sup> Floor Suite 100  
Memphis, TN 38112  
901-636-6574**

Complaint forms are available on the COM intranet. You may also file a complaint with the Secretary of Health and Human Services within 180 days of when the act or omission complained occurred. There will be no retaliation for filing a complaint with the COM or the Secretary of Health and Human Services.

#### **Contact Information**

To obtain access, amend, or receive an accounting of disclosures of your PHI or receive a paper copy of this Notice you may contact the Plan's Benefit Manager at the address below:

**Benefit Manager  
COM Employee Group Health Plan  
2714 Union Avenue Extended 5<sup>th</sup> Floor Suite 100  
Memphis, TN 38112  
901-636-6479**

**THIS NOTICE DESCRIBES HOW  
MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN  
ACCESS TO YOUR HEALTH INFORMATION.  
PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the City of Memphis (COM) Employee Benefit Health Plan (medical, surgical and mental health/substance abuse programs and prescription programs, collectively referred to as the Plans') to notify plan participants about its practices to protect the confidentiality of their protected health information (PHI). PHI is any information that may identify you and that relates to your past, present, or future physical or mental health condition and any related health care services and payment for those health care services. This Notice describes how the Plans may use and disclose PHI to carry out treatment, payment, or health care operations or other specified purposes permitted or required by law. The Notice also provides you information about your rights to access, to amend, and control the disclosure of your PHI.

The City of Memphis Health Plan is required to abide by the terms of this Notice, but reserve the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all PHI that the Health Plan maintains at that time. If a change is made to this Notice, a copy of the revised Notice will be provided to all individuals covered under the Health Plan at that time.

Effective Date: April 14, 2003

Revised: January 26, 2013

**USES AND DISCLOSURE OF YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN  
AUTHORIZATION**

**For Treatment.** The Plans may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plans may advise an emergency room physician about the types of prescription drugs you currently take.

**Uses and Disclosure for Payment.** The Plans may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plans may receive and maintain information about a surgery you received to enable the Plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf, or the Plans may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

**Uses and Disclosure for Health Care Operations.** The Plans may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the Plans may use and disclose your PHI for the Plans' administration activities such as quality assessments, case management, disease management programs, care coordination and other Plan-related activities including audits of claims.

**Use and Disclosure to the Plan Sponsor.** The Plans may disclose health information to City of Memphis, but City of Memphis has put protections in place to assure that the information will only be used for plan administration purposes, and never for employment purposes.

**Individual Involved in Your Care or Payment.** In limited circumstances, the plans may disclose your PHI to a close friend or family involved in or who helps pay for your health care. The Plans may also, upon request, advise a family member or close friend about your condition, your location (for example, inform an individual that you are in the hospital), or death. If you do not want such information to be shared with these individuals, you may request that these disclosures be restricted as provided in the section of this notice dealing with your rights.

**Business Associate.** Certain services are provided to the Plans by third party administrators or other vendors who are known as “business associates.” The Plans may disclose your PHI to these business associates in connection with their services for the Plan. For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan’s business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment functions. However, the Plans will require its business associates, through contract, to appropriately safeguard the privacy of your health information. As well, HIPAA requires business associates to comply directly with many of the HIPAA provisions for safeguarding PHI.

### **USES AND DISCLOSURES PERMITTED AND REQUIRED BY THE PLANS**

The Plans may use or disclose your PHI for any purpose required by law. The Plans are required or permitted to use or disclose your PHI without your authorization under the following circumstances:

**Public Health Risk.** The Plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify participants of recalls of products they have been using.

**Health Oversight Activities.** The Plans may disclose your PHI to a health oversight agency for audits, investigations, inspections and licensure necessary for the government to monitor the health care system and government programs.

**Judicial and Administrative Proceedings.** If you become involved in a lawsuit or other legal action, the Plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

**Law Enforcement Purposes.** The Plans may release your PHI if asked to do so by a law enforcement official. For example, to identify or locate a suspect, material witness, or missing person, or to report a crime, the crime’s location or victims, or the identify, description, or location of the person who committed the crime.

**Coroners, Medical Examiners, and Funeral Directors.** The Plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plans may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

**Organ/Eye/Tissue Donation.** If you are an organ donor, the Plans may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

**Certain Limited Research Activities.** The Plans may disclose information to researchers when an Institutional Review Board has reviewed and approved the research proposal, established protocols to ensure the privacy of your health information and granted a waiver of the authorization requirement.

**Health and Safety.** The Plans may consistent with applicable law and standards of ethical conduct disclose your PHI if the Plans, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

**Government Functions.** The Plans may use and disclose your PHI for specialized government functions. For example, if you are in the Armed Forces or a veteran for purposes of certain national security; Presidential protection and intelligence activities.

**Work-Related Illness and Injuries.** The Plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with City's On-the-Job Injury Program or others for the purposes related to employer occupational health and safety laws.

**Communication related to your health.** The Plans may use and disclose your PHI to provide information to you about disease management programs, treatment alternatives or other health-related benefits and services that may be of interest to you.

**Fundraising and Marketing.** The Plan will NOT use or disclose your PHI for fundraising or marketing purposes, as defined by HIPAA and its implementing regulations.

All other uses and disclosures of your protected health information will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. Certain uses and disclosures of psychotherapist notes will also require your written authorization.

## **YOUR INDIVIDUAL RIGHTS**

Your rights regarding the health information the Plans maintain about you are as follows:

**Right to Inspect and Copy.** You have the right to inspect and copy your PHI maintained in a "designated record set", generally with thirty (30) days of your request. The designated record set consists of records used in making payment, claims adjudication, medical management and other decisions, but does not include psychotherapy notes. If your PHI is maintained by the Plans in electronic format, you have the right to obtain a copy in electronic format and to direct that the Plan transmit the copy to an entity or person that you designate. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

**Right to Amend.** If you believe that health information is incorrect or incomplete, you may ask the plans in writing to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plans. You must provide the reason (s) to support your request.

Generally, the Plans have sixty (60) days to respond to your request, advising you of whether the amendment has been accepted or denied and informing you of details relevant to the acceptance or denial of your request. The Plans may deny your request if you ask the Plans to amend health information that was: (1) accurate and complete; (2) not created by the Plan; (3) not part of the health information kept by the Plan; or (4) not information that you would be permitted to inspect or copy. If your request is denied, you have the right to submit a statement disagreeing with the denial. The Plans must keep a copy of your request for amendment and any statement disagreeing with the denial of the amendment with your PHI and must disclose such documents when it discloses the PHI that is the subject of the requested amendment.

**Right to an Accounting of Disclosures.** You have the right to request in writing an “accounting of disclosures.” This is a list of disclosure of your PHI that the Plans has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations in accordance with HIPAA law and regulations. Your request must state a time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. Generally, the Plans have sixty (60) days to respond to your request. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable. If the Plans uses or maintains your PHI in an electronic health record (created by health care clinicians or staff and transferred to the Plan), you may have a right to an additional, limited accounting of disclosures of health records, in accordance with the amendments to HIPAA under the HITECH Act of 2009.

**Right to Request Restrictions.** You have the right to request in writing a restriction on the health information the Plans use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plans discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plans not use or disclose information about a surgery you had. You must advise the Plan: (1) what information you want to limit; (2) whether you want to limit the Plan’s use, disclosure, or both; and (3) to whom you want the limit(s) to apply. **Note:** The Plans are not required to agree to your request, except in circumstances after February 2010 where you are requesting that PHI not be disclosed to a health plan for payment or health care operations if the PHI relates solely to a service or item for which you have paid for in full out of pocket.

**Right to Request Confidential Communication.** You have the right to request in writing that the Plans communicate with you regarding your health matters by alternative means or at alternative locations. For example, you can ask that messages not be left on voice mail or sent to a particular address. Your request must specify that disclosure of all or part of the information could endanger you, how or where you wish to be contacted and, where applicable, how payment for this service will be handled. The Plan will accommodate all reasonable requests.

**Breach Notification.** You have a right to receive notification in the event the Plans discovers a breach of your unsecured Protected Health Information and determine notification is required by HIPAA.

**Right to a copy of this Notice.** You have the right to request a paper copy of this Notice at any time by sending a written request to the Benefit Manager at the address on the last page of this Notice. You may also read and download a copy from our website:

[www.cityofmemphis.gov](http://www.cityofmemphis.gov)

## **Attachment II – EAP/Mental Health and Substance Abuse**

### **DESIGNATED PROVIDERS**

#### **Mental Health and Substance Abuse Services**

##### **Covered Services - Employee Assistance Program (EAP)**

If you or any one of your Dependents requires Mental Health and Substance Abuse Services, please contact the Concern EAP at (901) 458.4000 or *if* out of area 1.800.445.5011.

EAP is a prepaid benefit for all City of Memphis Employees. We encourage all employees to seek assistance through the EAP first. Once your prepaid benefit is exhausted or further treatment needed, you must contact Cigna Behavioral Advantage to coordinate treatment for your Health Coverage to pay.

#### **CONCERN EAP for Short Term Mental Health and Substance Abuse Care**

##### ***For Active Employees and dependents only***

Short-term Counseling: CONCERN (EAP) provides short-term counseling and professional assistance for you, your dependents, and your household members who are experiencing quality of life problems. This service is available 24 hours per day and free to you and any member of your household--even if they are not covered by a City Of Memphis medical health option. There is no need to file a claim form since this care is prepaid by the *City* of Memphis.

##### **Covered Services - Medical Plan**

#### **Cigna Behavioral Advantage for Extended Treatment of Mental Health and Substance Abuse**

***For active Employees/Retirees and covered dependents*** When more complex or extended term mental health or substance abuse treatment is necessary, Cigna Behavioral Advantage provides a nationwide network of specialists.

You should call Cigna Behavioral Advantage at 1-800-Cigna24 to verify coverage and request any  
You should call Cigna Behavioral Advantage at 1-800-Cigna24 to verify coverage and request any required authorizations prior to receiving any treatment. Without authorization, you will be responsible for paying all charges and no benefits will be paid.

If medical treatment is required, you will be referred back to your Primary Care Physician (PCP) or medical doctor.

Your health coverage pays part of the cost of this type of care. Refer to the Covered Expenses section of this booklet for details about mental health and substance abuse benefits. Since benefits are payable for this type of care, it is available only to you and eligible dependents covered by your City of Memphis Medical plan.

## Attachment III – Preventive Services

Preventive health coverage is one of the most important benefits of your health plan. Getting the right preventive services at the right time can help you stay healthy by preventing diseases or by detecting a health problem at a stage that may be easier to treat.

However, because certain services can be done for preventive or diagnostic reasons, it's also important you understand exactly what preventive care is and which services your health plan covers as preventive services so you don't end up with unexpected out-of-pocket costs.

### **What is preventive care?**

Preventive care services are those provided when you don't have any symptoms of a disease or medical condition and are not already diagnosed with the condition for which the preventive service would be provided. Preventive care helps you to prevent some illnesses, such as the flu, by getting a vaccine against the disease. It also helps to detect illness that is present, but where there aren't any symptoms.

During your visit, your doctor will determine what tests or health screenings are right for you based on your age, gender, personal health history and current health. Even if you're in the best shape of your life, a serious condition with no signs or symptoms may put your health at risk. Through preventive exams and routine health screenings, your doctor can detect early warning signs of more serious problems.

Your plan covers preventive care services. The Patient Protection and Affordable Care Act require that preventive care services be covered with no patient cost-sharing (deductible, coinsurance or co-payment). If your plan has in-network and out-of-network coverage, the preventive care services are likely covered with no patient cost-sharing only when you receive it from an in-network health care professional. For plans that are exempt or not required to comply with the Act yet, you may be responsible for paying a portion of the cost of preventive care services from in-network and out-of-network health care professionals as applicable. Non-preventive or diagnostic services/supplies that are provided at the time of a preventive care office visit will be considered under your standard medical coverage. This means you may be required to pay a deductible, co-pay or coinsurance amount for covered services or supplies that are not preventive. Please refer to your plan materials for specific details about the coverage and cost-share responsibilities under your plan. Services and supplies considered as preventive care under your plan are described on the following pages<sup>1</sup>.

## Wellness exams and immunizations

	<b>Birth to 2 years</b>	<b>Ages 3 to 10</b>	<b>Ages 11 to 21</b>	<b>Ages 22 and older</b>
<b>Well-baby/well-child/ well-person exams including annual well-woman exam</b> (includes height, weight, head circumference, BMI, blood pressure, history, anticipatory guidance, education regarding risk reduction, psychosocial/behavioral assessment)	Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months. Additional visit at 2–4 days for infants discharged less than 48 hours after delivery	Well child exams; once a year	Once a year	Periodic visits, as doctor advises
Diphtheria, Tetanus Toxoids and Acellular Pertussis (DTaP)	2, 4 and 6 months and 15–18 months	Ages 4–6	Tetanus, diphtheria, acellular pertussis (Tdap) given once, ages 11 and older	Tetanus and diphtheria toxoids booster (Td) every 10 years; Tdap given once, ages 11 and older
Haemophilus influenzae type b conjugate (Hib)	2, 4 and 6 months and 12–15 months			
Hepatitis A (HepA)	12–23 months			May be required for persons at risk
Hepatitis B (HepB)	At birth, 1–4 months and 6–18 months	Ages 3–10 if not previously immunized	Ages 11–18 if not previously immunized	May be required for persons at risk
Human papillomavirus (HPV) (gender criteria apply depending on vaccine brand)		Ages 9–10, as doctor advises	Ages 11–12, catch-up, ages 13–26	Catch-up, through age 26
Influenza vaccine	Annually 6 months and older	Annually	Annually	Annually
Measles, mumps and rubella (MMR)	Ages 12–15 months	Ages 4–6	If not already immune	Rubella for women of childbearing age if not immune
Meningococcal (MCV)			All persons ages 11–18	
Pneumococcal (pneumonia)	2, 4 and 6 months and 12–15 months			Ages 65 and older, once (or younger than 65 for those with risk factors)
Poliovirus (IPV)	2 and 4 months and 6–18 months	Ages 4–6		
Rotavirus	Ages 6–32 weeks			
Varicella (chickenpox)	Ages 12–15 months	Ages 4–6	Second dose catch-up or if no evidence of prior immunization or chickenpox	Second dose catch-up or if no evidence of prior immunization or chickenpox
Zoster (shingles)				Ages 60+

## Health screenings and interventions

	Birth to 2 years	Ages 3 to 10	Ages 11 to 21	Ages 22 and older
Alcohol misuse				All adults
Aspirin to prevent cardiovascular disease <sup>2</sup>				Men ages 45–79; women ages 55–79
Autism	18, 24 months			
Cholesterol/lipid disorders	Screening of children and adolescents (after age 2, but by age 10) at risk due to known family history; when family history is unknown; or with personal risk factors (obesity, high blood pressure, diabetes)		Ages 20 and older if risk factors	All men ages 35 and older, or ages 20–35 if risk factors All women ages 45 and older, or ages 20–45 if risk factors
Colon cancer screening				The following tests will be covered for colorectal cancer screening, ages 50 and older: <ul style="list-style-type: none"> <li>• Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually</li> <li>• Flexible sigmoidoscopy every 5 years</li> <li>• Double-contrast barium enema (DCBE) every 5 years</li> <li>• Colonoscopy every 10 years</li> <li>• Computed tomographic colonography (CTC)/virtual colonoscopy every 5 years</li> </ul>
Congenital hypothyroidism screening	Newborns			
Depression screening			Ages 12–18	All adults
Developmental screening	9, 18 months	30 months		
Developmental surveillance	Newborn 1, 2, 4, 6, 12, 15, 24 months	At each visit	At each visit	
Diabetes screening				Adults with sustained blood pressure greater than 135/80
Dental caries prevention (Evaluate water source for	Children older than 6 months	Children older than 6 months		
Oral health evaluation/ assess for dental referral	12,18, 24 months	30 months, 3, 6 years		
Hearing screening (not complete hearing examination)	All newborns by 1 month	4, 5, 6, 8 and 10 or as doctor advises		
Healthy diet/nutrition counseling		Ages 6 and older – to promote improvement in weight status	Ages 6 and older – to promote improvement in weight status	Adults with hyperlipidemia, those at risk for cardiovascular disease or diet-related chronic disease
Hemoglobin or hematocrit	12 months			
HIV screening			Adolescents at risk	Men at risk
Iron supplementation <sup>2</sup>	6–12 months for children at risk			
Lead screening	12, 24 months			
Metabolic/hemoglobinopathies	Newborns			
(according to state law)				
Obesity screening		Ages 6 and older	Ages 6 and older	All adults

## Health screenings and interventions

	<b>Birth to 2 years</b>	<b>Ages 3 to 10</b>	<b>Ages 11 to 21</b>	<b>Ages 22 and older</b>
PKU screening	Newborns			
Prophylactic ocular (eye) medication to prevent blindness	Newborns			
Prostate cancer screening (PSA)				Men ages 50 and older or age 40 with risk factors
Sexually transmitted infections (STI) screening			All sexually active adolescents	All adults at risk
Sickle cell disease screening	Newborns			
Skin cancer prevention counseling to minimize exposure to ultraviolet radiation		Ages 10–24 years	Ages 10–24 years	Ages 10–24 years
Syphilis screening			Individuals at risk	Adults at risk
Tobacco use/cessation interventions				All adults
Tuberculin test	Children at risk	Children at risk	Adolescents at risk	
Ultrasound aortic abdominal aneurysm screening				Men ages 65–75 who have ever smoked
Vision screening (not complete eye examination)		3, 4, 5, 6, 8 and 10 or as doctor advises	12, 15 and 18 or as doctor advises	

## Women's health screenings and interventions

Anemia screening	Pregnant women
Bacteriuria screening	Pregnant women
Discussion/referral for counseling related to BRCA1/BRCA2 test	Women at risk
Discussion about potential benefits/risk of breast cancer preventive medication	Women at risk
Breast cancer screening (mammogram)	Women ages 40 and older, every 1–2 years
Breast-feeding support/counseling, supplies <sup>3</sup>	During pregnancy and after birth
Cervical cancer screening (pap test)	Ages 21–65, every 3 years
HPV DNA test with pap test	Women ages 30–65 every 5 years
Chlamydia screening	Sexually active women ages 24 and under and older women at risk
Contraception counseling/education. Contraceptive products and services <sup>4,5</sup>	Women with reproductive capacity
Counseling on sexually transmitted diseases	Sexually active women, annually
Domestic and interpersonal violence screening	All women
Folic acid supplementation <sup>2</sup>	Women planning or capable of pregnancy
Gestational diabetes screening	Pregnant women
Gonorrhea screening	Sexually active women at risk
Hepatitis B screening	Pregnant women
HIV screening and counseling	Sexually active women, annually
Osteoporosis screening	Age 65 or older (or under age 65 for women at risk)
Rh incompatibility test	Pregnant women
Syphilis screening	Pregnant women
Tobacco use/cessation interventions	Pregnant women

**Other coverage:** Your plan supplements the preventive care services listed above with additional services that are commonly ordered by primary care physicians during preventive care visits. These include services such as urinalysis, EKG, thyroid screening, electrolyte panel, Vitamin D measurement, bilirubin, iron and metabolic panels.

## **Attachment IV – Prescription Drug Benefits**

### **PRESCRIPTION DRUG BENEFITS**

Administered by Caremark

The City of Memphis has chosen Caremark to administer its prescription drug program. Benefits and restrictions are subject to change as determined by the City of Memphis.

Questions Concerning the Caremark Prescription Drug Plan and Coverage:

Call Caremark at 1-866-722-2001, Monday through Friday, 7 a.m. to 9 p.m. (CST). You also may access Caremark at [www.caremark.com](http://www.caremark.com).

Caremark has a team of customer service representatives trained to answer questions concerning your City drug coverage. Caremark representatives have immediate access to your claims and mail order records.

#### **Generic Drugs:**

A generic drug should be considered whenever possible. Generic medications are chemically equivalent to their brand name counterparts. Ask your doctor or pharmacist if your prescription can be filled with a Generic drug. Generic drugs offer substantial cost savings over brand name drugs. In addition, your plan design encourages generic usage through lower copayments.

Please be aware that:

- The City's prescription benefit plan design may not cover certain categories of drugs regardless of their appearance on the formulary such as vitamins, fertility products; and
- The formulary is updated regularly as new drugs come on the market.

#### **Deductible:**

There is a \$25.00 individual prescription drug deductible and a \$75 family deductible. The deductible year runs Jan 1 to Dec 31st. Each member must meet his or her deductible before the plan will begin picking up the balance of the drug costs after the member makes his or her copayment.

#### **Co-Pays:**

	Generic	Brand name- Formulary	Brand name- Non-formulary
1-30 day supply	\$10.00	\$20.00	\$40.00
31-60 day	\$20.00	\$40.00	\$80.00
90 day supply- mail	\$20.00	\$40.00	\$80.00

### **Retail Pharmacy- Short and Long Term Medications**

Prescriptions for up to a 30-day supply are considered short-term medications that can be filled at a retail pharmacy. For example, if you fill a prescription for a 31-day supply at a retail pharmacy, you will pay two copays. Prescriptions for a 31-day supply are considered long-term medications. These may be filled at a retail pharmacy, and you will pay two copays. Your prescription must be written for the greater supply, the pharmacy cannot use refills to supplement the amount dispensed. When filling your prescription, bring your Caremark ID card to the pharmacy so the pharmacist can verify your eligibility and fill your prescription. Your health card also has Caremark information that may be used to obtain medications.

The City of Memphis has contracted with Caremark to provide you access to over 50,000 participating pharmacies nationwide, including over 20,000 independent pharmacies.

### **Mail Service Program- Long Term Medications**

The Caremark Mail Service Program can be used to obtain your maintenance medications and is a cost-effective choice because you can obtain up to a 90-day supply for one copayment. Some typical conditions requiring maintenance medications are: allergies, asthma, cardiovascular treatments, depression, diabetes, high blood pressure, high cholesterol, or ulcers. Caremark's Mail Service Pharmacy purchases large quantities of these medications at a substantial discount. Using the Caremark Mail Service Pharmacy reduces out of pocket expenses for patients on longer-term maintenance Medications.

To begin receiving your maintenance medication from the Mail Service Program, ask your doctor to write you two prescriptions-

- One prescription to be filled immediately at a retail pharmacy so that you may have a supply of medication until you receive your order from the Mail service Program.
- One prescription for up to a 90-day supply plus refills to be filled through the Mail Service Program. In order to take advantage of the cost savings associated with the mail program, you must have your physician write the prescription for a 90-day supply with refills. If your physician writes the prescription as a 30-day supply with refills, you will receive a 30-day supply through the mail at the mail copays. Please send the original prescription (a photocopy will not be accepted), Patient Profile/Order Form and the appropriate copayment for the prescription. Caremark will send your prescription within 14 days after receiving your order with instructions on how to order your next 90-day supply of medication.

### **Drug Coverage**

The City of Memphis covers medications that are being prescribed for approved F.D.A. uses only. For example, prenatal vitamins are covered only if the patient is pregnant.

The following is a partial listing of categories of drugs with special coverage rules and restrictions. The list is not the complete list of drugs covered under the plan and does not necessarily cover all drugs with special coverage rules or restrictions and is intended to be used only as a guide. If you have questions regarding the coverage of a specific drug for a specific condition, please call Caremark at 1-866-722-2001.

### **Biotech Medications Covered Exclusively Through Caremark Therapeutic Services:**

Biotech medications are very costly as a general rule. Biotech medications are covered as appropriate only when purchased through Caremark Therapeutic Services (CTS). The list of Biotech drug categories generally covered through Caremark Therapeutic Services includes:

- Blood Modifiers
- Crohn's Disease
- Cystic Fibrosis
- Genetic Emphysema
- Growth Hormones
- Hemophilia
- Hepatitis C
- Immune Disorders
- Multiple Sclerosis
- RSV/RSV Disease Preventions, and
- Rheumatoid Arthritis medications.

Please contact CVS at 1-800-237-2767 to arrange for coverage of these medications. Categories of coverage may be added from time to time as deemed appropriate by the City of Memphis.

### **Medications Covered Only with Specific Quantity Limitations:**

The list of medications covered only with specific quantity limitations includes Imitrex, Caverject, Edex, Muse, and Viagra.

Quantity specific limitations may be placed on other medications from time to time as deemed appropriate by the City of Memphis.

### **Medications Requiring a Particular Diagnosis for Coverage:**

The following types of medications require a particular diagnosis for coverage. The list of medications requiring a particular diagnosis for coverage includes, but is not limited to:

- Lupron-not covered for fertility purposes;
- Contraceptive Injectibles – not covered for contraceptive purposes;
- Prenatal Vitamins – covered only when diagnosis is pregnancy;
- Diet Medications – covered only when diagnosis is morbid obesity;
- Adderall – covered only with particular diagnosis;
- Ritalin – covered only with particular diagnosis.

These diagnosis-specific medications are only covered through the mail service after one time only coverage at retail. You must contact Caremark to receive your ongoing supply of these medications.

Diagnosis specific limitations may be placed on other medications from time to time as deemed appropriate by the City of Memphis.

### **Medications Not Covered by the Plan**

- Syringes (other than insulin)
- Vitamins (other than prenatal vitamins during pregnancy)
- Fertility drugs

Other medications may be excluded from coverage from time to time as deemed appropriate by the City of Memphis.

**Utilization Management- Mail Service Program**

After receiving your mail order prescription, Caremark may contact your doctor or your doctor's authorized representative to request consideration of a formulary product or a generic equivalent, even if the prescription is marked by the physician "dispense as written". This may result in your doctor authorizing Caremark to prescribe a different brand name drug or a generic equivalent in place of your original prescription. If your doctor does not approve the change, Caremark will fill your prescription as originally written.