

SERFF Tracking Number: CCGH-126875476 State: Arkansas
Filing Company: CIGNA Health and Life Insurance Company State Tracking Number: 47225
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002C Large Group Only - Other
Product Name: Group Medical Retiree Plan
Project Name/Number: /CCGH-126875476

Filing at a Glance

Company: CIGNA Health and Life Insurance Company

Product Name: Group Medical Retiree Plan SERFF Tr Num: CCGH-126875476 State: Arkansas
TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 47225
Closed

Sub-TOI: H16G.002C Large Group Only - Other Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Disposition Date: 11/19/2010
Author: Melissa Pine Disposition Status: Approved-Closed
Date Submitted: 11/05/2010

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:
Project Number: CCGH-126875476
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filed
simultaneously in Connecticut our state of
domicile.

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Market Type: Group

Group Market Size: Large

Group Market Type: Employer, Association,
Trust

Filing Status Changed: 11/19/2010

Explanation for Other Group Market Type:

State Status Changed: 11/19/2010

Deemer Date:

Created By: Karen Martocci

Submitted By: Melissa Pine

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

Filing Description:

We are submitting for your approval certificate insert pages for a retiree medical plan to be used with CIGNA Health and Life Insurance Company Medical Master Policy documents (the HP form series) and Master Certificate documents (the HC form series) approved by your Department on September 14, 2010 under SERFF filing number CCGH-126653734.

These certificate insert pages provide medical benefits for Medicare eligible retirees and their dependents. This plan is

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 not a Medicare Supplement plan.

State mandates were reviewed and applicable mandates were included in certificate rider form HC-RDR21.

These forms are new and do not replace any on file with your Department.

The bracketed language on these forms is considered variable. A statement of variability is included.

Company and Contact

Filing Contact Information

Karen Martocci, Compliance Specialist karen.martocci@cigna.com
 900 Cottage Grove Road 860-226-5631 [Phone]
 B6LPA 860-226-5400 [FAX]
 Hartford, CT 06152

Filing Company Information

CIGNA Health and Life Insurance Company CoCode: 67369 State of Domicile: Connecticut
 900 Cottage Grove Road Group Code: 901 Company Type: LAH
 Bloomfield, CT 06002 Group Name: State ID Number:
 (860) 226-6000 ext. [Phone] FEIN Number: 59-1031071

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
CIGNA Health and Life Insurance Company	\$50.00	11/05/2010	41578070
CIGNA Health and Life Insurance Company	\$1,200.00	11/19/2010	42112969

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/19/2010	11/19/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	11/16/2010	11/16/2010			

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Additional Filing Fee Submitted	Note To Reviewer	Melissa Pine	11/19/2010	11/19/2010

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Disposition

Disposition Date: 11/19/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Forms Listing	Approved-Closed	Yes
Form	Additional Programs	Approved-Closed	Yes
Form	Important Notices	Approved-Closed	Yes
Form	How to File Your Claim	Approved-Closed	Yes
Form	Eligibility – Effective Date	Approved-Closed	Yes
Form	Schedule of Insurance	Approved-Closed	Yes
Form	Covered Expenses	Approved-Closed	Yes
Form	Exclusions, Expenses Not Covered and General Limitations	Approved-Closed	Yes
Form	Payment of Benefits	Approved-Closed	Yes
Form	Termination of Insurance	Approved-Closed	Yes
Form	Dependent	Approved-Closed	Yes
Form	Eligible Person	Approved-Closed	Yes
Form	Hospice Care Services	Approved-Closed	Yes
Form	Hospital	Approved-Closed	Yes
Form	Hospital Confinement Or Confined In A Hospital	Approved-Closed	Yes
Form	Medicare Approved Amount	Approved-Closed	Yes
Form	Medicare Eligible Expenses	Approved-Closed	Yes
Form	Medicare Part A Benefit Period	Approved-Closed	Yes
Form	Medicare Part A Deductible	Approved-Closed	Yes
Form	Medicare Part B Deductible	Approved-Closed	Yes
Form	Original Medicare Plan	Approved-Closed	Yes
Form	Physician	Approved-Closed	Yes
Form	Related Plan	Approved-Closed	Yes
Form	Sickness	Approved-Closed	Yes
Form	Skilled Nursing Facility	Approved-Closed	Yes
Form	Legislation Rider	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 11/16/2010

Submitted Date 11/16/2010

Respond By Date

Dear Karen Martocci,

This will acknowledge receipt of the captioned filing.

Objection 1

- Flesch Certification (Supporting Document)
- Application (Supporting Document)
- PPACA Uniform Compliance Summary (Supporting Document)
- Statement of Variability (Supporting Document)
- Forms Listing (Supporting Document)
- Additional Programs, HC-SPP9 (Form)
- Important Notices, HC-IMP75 (Form)
- How to File Your Claim, HC-CLM17 (Form)
- Eligibility – Effective Date, HC-ELG38 (Form)
- Schedule of Insurance , HC-SOC149 (Form)
- Covered Expenses, HC-COV177 (Form)
- Exclusions, Expenses Not Covered and General Limitations, HC-EXC55 (Form)
- Payment of Benefits, HC-POB31 (Form)
- Termination of Insurance, HC-TRM75 (Form)
- Dependent, HC-DFS373 (Form)
- Eligible Person, HC-DFS374 (Form)
- Hospice Care Services, HC-DFS375 (Form)
- Hospital, HC-DFS376 (Form)
- Hospital Confinement Or Confined In A Hospital, HC-DFS377 (Form)
- Medicare Approved Amount, HC-DFS378 (Form)
- Medicare Eligible Expenses, HC-DFS379 (Form)
- Medicare Part A Benefit Period, HC-DFS3780 (Form)
- Medicare Part A Deductible, HC-DFS381 (Form)
- Medicare Part B Deductible, HC-DFS382 (Form)
- Original Medicare Plan, HC-DFS383 (Form)
- Physician, HC-DFS384 (Form)

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- Related Plan, HC-DFS385 (Form)
- Sickness, HC-DFS386 (Form)
- Skilled Nursing Facility, HC-DFS387 (Form)
- Legislation Rider , HC-RDR21 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$1250.00. Please submit an additional \$1200.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Note To Reviewer

Created By:

Melissa Pine on 11/19/2010 08:33 AM

Last Edited By:

Rosalind Minor

Submitted On:

11/19/2010 10:04 AM

Subject:

Additional Filing Fee Submitted

Comments:

Hello,

I've submitted the additional \$1200 via EFT as requested. However, SERFF is not allowing me to respond to your objection to let you know that I have done so. I tried to submit via a post-submission amendment and that didn't work either. In any event, the money is out there so I'm trying the "note to reviewer" to let you know.

Hope this works.

Melissa

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Post Submission Update Request Processed On 11/19/2010

Status: Allowed
Created By: Melissa Pine
Processed By: Rosalind Minor
Comments:

General Information:

Field Name	Requested Change	Prior Value
Project Number	CCGH-126875476	

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Form Schedule

Lead Form Number: HC-SPP9

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/19/2010	HC-SPP9	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Additional Programs	Initial		46.400	HC-SPP9.pdf
Approved-Closed 11/19/2010	HC-IMP75	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Important Notices	Initial		46.400	HC-IMP75.pdf
Approved-Closed 11/19/2010	HC-CLM17	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	How to File Your Claim	Initial		46.400	HC-CLM17.pdf
Approved-Closed 11/19/2010	HC-ELG38	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Eligibility – Effective Date	Initial		46.400	HC-ELG38.pdf
Approved-Closed 11/19/2010	HC-SOC149	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Schedule of Insurance	Initial		46.400	HC-SOC149.pdf
Approved-	HC-	Certificate	Covered Expenses	Initial		46.400	HC-

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Product Name:	Group Medical Retiree Plan		
Project Name/Number:	/CCGH-126875476		
Closed	COV177	Amendmen	COV177.pdf
11/19/2010		t, Insert Page, Endorseme nt or Rider	
Approved- Closed	HC-EXC55	Certificate Exclusions, Amendmen Expenses Not	Initial 46.400 HC- EXC55.pdf
11/19/2010		t, Insert Covered and General Page, Limitations Endorseme nt or Rider	
Approved- Closed	HC-POB31	Certificate Payment of Benefits	Initial 46.400 HC- POB31.pdf
11/19/2010		t, Insert Page, Endorseme nt or Rider	
Approved- Closed	HC-TRM75	Certificate Termination of Amendmen Insurance	Initial 46.400 HC- TRM75.pdf
11/19/2010		t, Insert Page, Endorseme nt or Rider	
Approved- Closed	HC- DFS373	Certificate Dependent Amendmen	Initial 46.400 HC- DFS373.pdf
11/19/2010		t, Insert Page, Endorseme nt or Rider	
Approved- Closed	HC- DFS374	Certificate Eligible Person Amendmen	Initial 46.400 HC- DFS374.pdf
11/19/2010		t, Insert Page, Endorseme nt or Rider	
Approved- Closed	HC- DFS375	Certificate Hospice Care Amendmen Services	Initial 46.400 HC- DFS375.pdf
11/19/2010		t, Insert	

<i>SERFF Tracking Number:</i>	<i>CCGH-126875476</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Product Name:</i>	<i>Group Medical Retiree Plan</i>		
<i>Project Name/Number:</i>	<i>/CCGH-126875476</i>		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-	Certificate Hospital	Initial	46.400
Closed DFS376	Amendmen		
11/19/2010	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-	Certificate Hospital Confinement	Initial	46.400
Closed DFS377	Amendmen Or Confined In A		
11/19/2010	t, Insert Hospital		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-	Certificate Medicare Approved	Initial	46.400
Closed DFS378	Amendmen Amount		
11/19/2010	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-	Certificate Medicare Eligible	Initial	46.400
Closed DFS379	Amendmen Expenses		
11/19/2010	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-	Certificate Medicare Part A	Initial	46.400
Closed DFS3780	Amendmen Benefit Period		
11/19/2010	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-	Certificate Medicare Part A	Initial	46.400
Closed DFS381	Amendmen Deductible		
11/19/2010	t, Insert		
	Page,		
	Endorseme		

<i>SERFF Tracking Number:</i>	<i>CCGH-126875476</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Product Name:</i>	<i>Group Medical Retiree Plan</i>		
<i>Project Name/Number:</i>	<i>/CCGH-126875476</i>		
	nt or Rider		
Approved- HC- Closed DFS382 11/19/2010	Certificate Medicare Part B Amendmen Deductible t, Insert Page, Endorseme nt or Rider	Initial	46.400 HC- DFS382.pdf
Approved- HC- Closed DFS383 11/19/2010	Certificate Original Medicare Amendmen Plan t, Insert Page, Endorseme nt or Rider	Initial	46.400 HC- DFS383.pdf
Approved- HC- Closed DFS384 11/19/2010	Certificate Physician Amendmen t, Insert Page, Endorseme nt or Rider	Initial	46.400 HC- DFS384.pdf
Approved- HC- Closed DFS385 11/19/2010	Certificate Related Plan Amendmen t, Insert Page, Endorseme nt or Rider	Initial	46.400 HC- DFS385.pdf
Approved- HC- Closed DFS386 11/19/2010	Certificate Sickness Amendmen t, Insert Page, Endorseme nt or Rider	Initial	46.400 HC- DFS386.pdf
Approved- HC- Closed DFS387 11/19/2010	Certificate Skilled Nursing Amendmen Facility t, Insert Page, Endorseme nt or Rider	Initial	46.400 HC- DFS387.pdf
Approved- HC-RDR21	Certificate Legislation Rider	Initial	46.400 HC-

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Product Name: Group Medical Retiree Plan
Project Name/Number: /CCGH-126875476
Closed Amendmen RDR21.pdf
11/19/2010 t, Insert
Page,
Endorseme
nt or Rider

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to Eligible Persons and their Dependents for the purpose of promoting their general health and well being. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

**THIS IS NOT A STANDARDIZED
MEDICARE SUPPLEMENT PLAN**

HOW TO FILE YOUR CLAIM

Upon enrollment, for smoother claim payment, you should provide CIGNA with your Medicare Claim Number as it appears on your Medicare I.D. card. You can:

- Enter it at **myCIGNA.com** or
- Call CIGNA Customer Service at the number on the back of your CIGNA I.D. card.

You must submit expenses covered by this plan to Medicare before they can be considered for payment under this plan. Hospitals, Skilled Nursing Facilities, home health agencies, and Physicians are required by law to file Medicare claims for covered services and supplies that you receive.

If you visit your doctor or hospital, your doctor or hospital will send a claim directly to Medicare. Medicare will pay their part and will send the claim to CIGNA. You will receive a Medicare Summary Notice (MSN) from Medicare. The Summary Notice will list your Medicare claims information including a note if the information was sent to your private insurer (CIGNA) for additional benefits.

For services not covered by Medicare but covered by this plan, you will need to send a claim form to CIGNA. You may get the required claim forms from your Benefit Plan Administrator, by calling customer service or from our website at www.CIGNA.com. All fully completed claim forms and bills should be mailed directly to the claim address that appears on the back of your CIGNA ID card.

CLAIM REMINDERS:

- BE SURE TO USE YOUR CIGNA MEMBER ID AND ACCOUNT /GROUP NUMBER WHEN YOU FILE [CIGNA's] CLAIM FORMS, OR WHEN YOU CALL CIGNA CUSTOMER SERVICE.
YOUR MEMBER ID IS THE ID SHOWN ON YOUR [CIGNA] IDENTIFICATION CARD.
YOUR CIGNA ACCOUNT /GROUP NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR CIGNA IDENTIFICATION CARD.
PROVIDE YOUR MEDICARE CLAIM IDENTIFICATION NUMBER AS IT APPEARS ON YOUR MEDICARE ID CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM [TO CIGNA].

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

ELIGIBILITY — EFFECTIVE DATE

Insurance for Eligible Persons

This plan is offered to you as an Eligible Person. To be insured, you may have to pay part of the cost.

You will become eligible for insurance on the day you are in a Class of Eligible Persons.

Classes of Eligible Persons

Each Eligible Person as reported to the insurance company by your Employer.

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by completing the application process, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election.

Add the following text when dependent coverage is elected.

[Insurance for Dependents

For your Dependents to be insured, you may have to pay part of the cost of Dependent Insurance.

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by completing the application process, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Eligibility Restrictions

The Eligible Person must enroll for coverage under either this plan or a Related Plan in order to enroll for Dependent Insurance.]

[CIGNA Medicare Surround]

Remove text for Part A only plans
(Part A [and Part B])

The Schedule

If plan does not include a deductible, copayments or Part B coverage, modify to remove references.

For Employee only plans, remove references "and your Dependents"

For You [and Your Dependents]

Part A benefits cover the same benefits covered under Medicare Part A. [Part B benefits cover the same benefits covered under Medicare Part B.] Unless otherwise noted, the benefits covered under this plan are limited to expenses approved by Medicare but not paid by Medicare. To receive benefits, you [and your Dependents] must pay a portion of the Covered Expenses. That portion is the [Deductible] [Copayment] [and] [Coinsurance].

Coinsurance

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

Include the following box only if the plan includes copayments or deductibles..

For Employee only plans, remove references "or your Dependent" and "and your family"

[Copayments

Copayments are expenses to be paid by you or your Dependent for the services received. Copayments are in addition to any Coinsurance.]

[Deductibles

Deductibles are expenses to be paid by you [or your Dependent]. Deductible amounts are separate from and are in addition to any Coinsurance. *Omit the following sentence for Benefit Deductible plans which do not elect a Plan Deductible* [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: Include the following box if OOP is included. Modify the paragraph below as needed

[Out of Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Part A [or Part B] expenses for:

- Coinsurance

Include "Deductible" when plan deductible is elected.

- [Deductible]

Include "per admission Deductible or Copayment" when Benefit Deductible or Copayment plan and days 1- 150th with a per admission deductible or copayment is elected

- [per admission [Deductible][Copayment]

Include when per day Deductible or Copayment is elected.

- per day [Deductible][Copayment]]

Include "per trip Deductible or Copayment " when Benefit Deductible or Copayment plan and Ambulance per trip deductible or copayment is elected

- [per trip [Deductible][Copayment]]

Include "per visit Deductible or Copayment" when Benefit Deductible or Copayment plan and per visit deductible or copayment is elected

- [per visit [Deductible][Copayment]]

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% *Only include Maximum Reimbursable if Part B buy-up options are selected.* [except for: Provider charges in excess of Maximum Reimbursable Charge.]]

Contract Year: *Use for all products when Contract Year is elected as the accumulation type. Complete to match the contract year accumulation period with month and day e.g., 03/01.*

[Contract Year] Contract Year means a twelve month period beginning on each [MM/DD.]		
BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] Remove column when Part B expenses are not covered under the plan design.
<i>Include text based on the plan selection</i> Lifetime Maximum Applies to Part [A and B] expenses	<i>Choose based on the plan selection</i> [\$ 250,000- unlimited]	
Coinsurance Levels Part A	Coinsurance as shown below of the amount approved by Medicare but not paid by Medicare	Not Applicable
<i>Include text boxes below when part B is covered and modify based upon plan design to include coverage for Part B deductible, include coverage for Remainder of expenses after the Part B deductible or include coverage for both. Vary to include/exclude plan deductible and vary coinsurance within the ranges shown.</i>		
[Part B Deductible]	[Not Applicable]	<i>Use the following when Medicare Part B Deductible is covered:</i> [25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare <i>Use the following when Medicare Part B Deductible is not covered:</i> [Not Covered]
[Remainder of expenses after the Part B Deductible]	[Not Applicable]	[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare or [Not Covered]
Part B Excess Charges – Include the following box if the Part B Excess Charges Buy-up is selected. Modify based on plan selection.		
[Part B Excess Charges] Charges above approved Medicare amounts for providers that do not accept the Medicare assignment	Not Applicable	25-100% after plan deductible up to the Medicare limiting charge, or the Maximum Reimbursable Charge whichever is less]
Maximum Reimbursable Charge: If the plan elects any Part B Buy Ups and Option 1 or Option 2 or for Maximum Reimbursable Charge, include the following box.		

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p>[Maximum Reimbursable Charge] Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or <i>Use the following if the plan selection is either Option 1 (Percentile)</i> A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected.</p>	<p><i>Use the following if plan is Option 1</i> Not Applicable</p>	<p><i>Use the following if plan is Option 1</i> <i>Add the percentile amount</i> [80th] [90th]th Percentile]</p>
<p><i>Use the following if the plan selection is Option 2 (Percentage)</i> [A percentage of a schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:</p> <ul style="list-style-type: none"> • the provider's normal charge for a similar service or supply; or • the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by CIGNA. 	<p><i>Use the following if plan is Option 2</i> Not Applicable</p>	<p><i>Use the following if plan is Option 2</i> <i>Add the percentage amount</i> [110-200%]]</p>
<p>[Note: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to any applicable deductibles, copayments and coinsurance.]</p>		
<p><i>Calendar/Contract Year Maximum:</i> <i>Include the following if the plan includes a calendar/contract year maximum</i></p>		

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
[[Calendar] [Contract] Year Maximum (Applies to Part A and Part B]expenses)	[\$20,000-unlimited]]	
Deductible : <i>Include the following boxes/ 2 column format if the plan includes a Deductible for Part B only. Note - Family Maximum is not standardly included.</i>		
[[Calendar] [Contract] Year Deductible (Applies to Part B expenses only)		
Individual <i>Only include the following if selected</i> [Family Maximum	Not Applicable <i>Only include the following if selected</i> Not Applicable	[\$1-\$5000 per person]] <i>Only include the following if selected</i> [\$1-\$10,000 per family]]
Individual Family Deductible: <i>Use in addition to standard deductible box above when family deductible is elected.</i>		
[Family Maximum Calculation Individual Calculation: Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.]		
Deductible : <i>Include the following boxes/1 column format if the plan includes a Deductible for Part A and Part B. Note - Family Maximum is not standardly included.</i>		
[[Contract] [Calendar] Year Deductible (Applies to Part A and Part B expenses)		
Individual <i>Only include the following if selected</i> [Family Maximum	[\$1-\$5000 per person]] <i>Only include the following if selected</i> [\$1-\$10,000 per family]]	

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
Individual Family Deductible: <i>Use in addition to standard deductible box above when family deductible is elected.</i>		
[Family Maximum Calculation Individual Calculation: Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.]		
OOB : <i>Include the following boxes/ 2 column format if the plan includes an OOB Max for Part B only. Note - Family Maximum is not standardly included.</i>		
[Out-of-Pocket Maximum] (Applies to Part B expenses only)		
Individual <i>Only include the following if selected</i> [Family Maximum]	Not Applicable <i>Only include the following if selected</i> Not Applicable	[\$1-\$5000 per person]] <i>Only include the following if selected</i> [\$1-\$10,000 per family]]
Individual Calculation: <i>Use in addition to standard OOB box above when individual OOB calculation is elected.</i>		
[Family Maximum Calculation Individual Calculation: Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.]		
OOB: <i>Include the following boxes/1 column format if the plan includes an OOB Max for Part A and Part B. Note - Family Maximum is not standardly included.</i>		
[Out-of-Pocket Maximum] (Applies to Part A and Part B expenses)		
Individual <i>Only include the following if selected</i> [Family Maximum]	[\$1-\$5000 per person]] <i>Only include the following if selected</i> [\$1-\$10,000 per family]]	
Individual Calculation: <i>Use in addition to standard OOB box above when individual OOB calculation is elected</i>		

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p>[Family Maximum Calculation</p> <p>Individual Calculation:</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>Inpatient Hospital - Facility Services</p> <p>Semi-private room and board, general nursing and miscellaneous services and supplies.</p> <p>A new benefit period begins each time the member is out of the hospital more than [30-180] days</p>		
<p><i>Add the following if the plan includes only the first 60 days (Medicare Part A deductible).</i></p>		
<p>[First 60 days per benefit period (Medicare Part A deductible)</p>	<p>[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare</p>	<p>Not Applicable</p>
<p>61st – 150th day per benefit period (using 60 lifetime reserve days)</p>	<p>Not Covered</p>	<p>Not Applicable]</p>
<p><i>Add the following if the plan includes only the 61st - 150th day.</i></p>		
<p>[First 60 days per benefit period (Medicare Part A deductible)</p>	<p>Not Covered</p>	<p>Not Applicable</p>
<p>61st – 150th day per benefit period (using 60 lifetime reserve days)</p>	<p>[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare</p>	<p>Not Applicable]</p>

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<i>Add the following if the plan includes days 1- 150th and modify to fit client specific plan design.</i>		
[Days 1 – 150 per benefit period (using 60 lifetime reserve days)	[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare	Not Applicable]
<i>Add the following if the plan includes days 1- 150th with a per admission deductible and modify to fit client specific plan design.</i>		
[Days 1 – 150 per benefit period (using 60 lifetime reserve days)	[\$25-3000 per admission deductible/copayment then 25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare	Not Applicable]
<i>Add the following if the plan includes days 1- 150th with a per day deductible and modify to fit client specific plan design.</i>		
[Days 1 – 150 per benefit period (using 60 lifetime reserve days)	[\$25-1500 per day deductible/copayment then 25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare	Not Applicable]
<i>Add the following if the plan includes days 1- 150th with coinsurance that varies at day intervals and modify to fit client specific plan design.</i>		
[Days 1-60 Days 61-90 Days 91-150	[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare [25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare [25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare	Not Applicable Not Applicable Not Applicable]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
Inpatient Hospital- Facility Charges Buy-up: <i>Use the following box if the plan includes the Buy-up for additional days and modify based on client specific plan.. Note: If buy up selected, MHSA in a psychiatric hospital must be unlimited.</i>		
<p>[Once Lifetime Reserve days are used (or would have ended if used) additional 365 days of confinement per person per lifetime <i>Choose based on plan selection</i> Days [1-365]</p>	<p>[25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare] or [\$25-1500 per day deductible/copayment then 25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare]</p>	<p>Not Applicable]</p>
<i>Include if coverage at Inpatient Services at Other Health care Facilities is included and vary based upon plan design.</i>		

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p>[Inpatient Services at Other Health Care Facilities</p> <p>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</p> <p>First 20 days</p> <p>21st – 100th day</p>	<p>Not covered by plan. Medicare pays in full.</p> <p><i>Choose based on plan selection</i></p> <p>[25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare]</p> <p><i>or</i></p> <p>[\$1-250 per day deductible/copayment then 25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare]</p>	<p>Not Applicable</p> <p>Not Applicable]</p>
<p><i>Inpatient Services at Other Health Care Facilities Buy-up: Use the following box if the plan includes 101st – 365th additional days for Other Health Care Facilities.</i></p>		
<p><i>Choose based on plan selection</i></p> <p>[101st – 365th day</p>	<p><i>Choose based on plan selection</i></p> <p>[25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare]</p> <p><i>OR</i></p> <p>[\$1-250 per day deductible/copayment then 25-100%]</p>	<p>Not Applicable]</p>
<p><i>Inpatient Services at Other Health Care Facilities Buy-up: Use the following box if the plan includes additional days 101 through 120 for Other Health Care Facilities.</i></p>		
<p>[101st – 120th day</p>	<p><i>Choose based on plan selection</i></p> <p>[25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare]</p> <p><i>OR</i></p> <p>[\$1-250 per day deductible /copayment then 25-100%]</p>	<p>Not Applicable]</p>

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<i>Inpatient Services at Other Health Care Facilities Buy-up:</i> Use the following box if the plan includes additional days 101 through 180 for Other Health Care Facilities.		
[101 st -180 th day	<p><i>Choose based on plan selection</i></p> <p>[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]</p> <p>OR</p> <p>[\$1-250 per day deductible /copayment then 25-100%]</p>	Not Applicable]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<i>Include the following box if Hospice is included.</i>		
[Hospice/Inpatient Respite Care (includes Bereavement Counseling)	[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare	Not Applicable]
<i>Include text if plan covers Part A expenses only and modify accordingly.</i>		
[*Inpatient Facility Services include, but are not limited to, expenses incurred for Advance Radiological Imaging, Maternity, Abortion, Family Planning, Organ Transplants, Dental Care and Mental Health and Substance Abuse.]		
[Physician's Services		
Primary Care Physician's Office Visit	Not Applicable	<i>Choose based on plan selection</i> [25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare] OR [\$1-150 PCP per office visit deductible/copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare]
Specialty Care Physician's Office Visit	Not Applicable	<i>Choose based on plan selection</i> [25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare] OR [\$1-150 Specialist per office visit deductible/copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare]
Surgery Performed In the Physician's Office	Not Applicable	<i>Choose based on plan selection</i> [25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare] OR [\$1-150 PCP or \$1-150 Specialist per office visit deductible/copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
Second Opinion Consultations (provided on a voluntary basis)	Not Applicable	<i>Choose based on plan selection</i> [25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare] OR [\$1-150 PCP or \$1-150 Specialist per office visit deductible/copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare]
Allergy Treatment/Injections	Not Applicable	<i>Choose based on plan selection</i> [25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]] OR [\$1-150 PCP or \$1-150 Specialist per office visit deductible/copayment then 100% of the amount approved by Medicare but not paid by Medicare]]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p>[Preventive Care</p> <p>Routine Physical age 18 and over (including screenings). Also covers one time per lifetime “Welcome to Medicare” exam.</p>	<p>Not Applicable</p>	<p><i>Choose based on plan selection</i></p> <p>[100% of the amount approved by Medicare but not paid by Medicare]</p> <p>OR</p> <p>[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]</p> <p>OR</p> <p>[25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare]</p>
<p>Immunizations age 18 and over (includes flu shots, hepatitis B shots and Pneumococcal shots)</p>	<p>Not Applicable</p>	<p><i>Choose based on plan selection</i></p> <p>[100% of the amount approved by Medicare but not paid by Medicare]]</p> <p>OR</p> <p>[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]]</p> <p>OR</p> <p>[25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare]]</p>

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
[Early Cancer Detection Screenings]	Not Applicable	[100% of the amount approved by Medicare but not paid by Medicare]] <i>Or</i> [25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]]
[Associated Exams]	Not Applicable	[100% of the amount approved by Medicare but not paid by Medicare]] <i>or</i> [\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]]
<i>Include for Coinsurance Plan Designs</i>		
[Outpatient Facility Services Operating Room, Recovery Room, Procedures Room and Treatment Room]	Not Applicable	[25-100% <i>after plan deductible</i>] of the amount approved by Medicare but not paid by Medicare]
<i>Include following 2 boxes for Benefit Deductible Plan Designs</i>		
[Outpatient Facility Services- Surgical Facility and Free Standing Ambulatory Surgery Center Operating Room, Recovery Room, Procedures Room and Treatment Room]	Not Applicable	[1-1500 per visit deductible/copayment then 25-100%] of the amount approved by Medicare but not paid by Medicare
Outpatient Facility Services Non-Surgical Facility Including but not limited to radiation therapy, chemotherapy, x-ray, MRI, CT Scan, PET Scan or lab services when done in an outpatient hospital facility	Not Applicable	[1-150 per visit deductible/copayment then 25-100%] of the amount approved by Medicare but not paid by Medicare]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] Remove column when Part B expenses are not covered under the plan design.
<p><i>The following Part B benefit text can be varied (as shown) to be included or not included, to include/not include plan deductible, to include/not include per visit deductible/copayment, to include/not include maximums and vary coinsurance:</i></p> <p><i>Inpatient Hospital Physician's Visits/Consultations, Inpatient Hospital Professional Services, Outpatient Professional Services, Emergency and Urgent Care Services, Laboratory and Radiology Service and Advanced Radiological Imaging, Outpatient Short-Term Rehabilitative Therapy, Home Health Care, Maternity, Abortion, infertility, Family Planning, Organ T ransplant, DME, EPA, Diabetic Supplies and Services, Clinical Trials, Dental Care, Routine Foot Disorders, Blood, Part B Covered Prescription Drugs, At Home Recovery, Smoking Cessation Counseling, Mental Health And Substance Abuse, foreign travel, hearing and vision.</i></p>		
<p>[Inpatient Hospital Physician's Visits/Consultations</p>	<p>Not Applicable</p>	<p>Choose based on plan selection [25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare] OR [\$1-150 PCP or \$1-150 Specialist per office visit deductible/copayment then 25-100% of the amount approved by Medicare but not paid by Medicare]</p>
<p>[Inpatient Hospital Professional Services Surgeon/Assistant Surgeon Radiologist Pathologist Anesthesiologist</p>	<p>Not Applicable</p>	<p>25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]]</p>
<p>[Outpatient Professional Services Surgeon/Assistant Surgeon Radiologist Pathologist Anesthesiologist</p>	<p>Not Applicable</p>	<p>25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]]</p>

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
[Emergency and Urgent Care Services		
Physician's Office Visit	[Not Applicable	<i>Choose based on plan selection</i> [25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare] <i>OR</i> [\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100 % of the amount approved by Medicare but not paid by Medicare]
Hospital Emergency Room	Not Applicable	<i>Choose based on plan selection</i> [25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare] <i>OR</i> [\$1-500 per visit deductible/copayment then 25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare. The per visit deductible is waived if the patient is admitted to the hospital.]
Emergency Room Physician	Not Applicable	[25-100% <i>after plan deductible</i>] of the amount approved by Medicare but not paid by Medicare
Urgent Care Facility or Outpatient Facility	Not Applicable	<i>Choose based on plan selection</i> [25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare] <i>OR</i> [\$1-150 per visit deductible/copayment, then 25-100 % <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare]
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	Not Applicable	[25-100% <i>after plan deductible</i>] of the amount approved by Medicare but not paid by Medicare

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
Independent x-ray and/or Lab Facility in conjunction with an ER visit	Not Applicable	[25-100% <i>after plan deductible</i>] of the amount approved by Medicare but not paid by Medicare
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	Not Applicable	[25-100% <i>after plan deductible</i>] of the amount approved by Medicare but not paid by Medicare
Ambulance	Not Applicable	<i>Choose based on plan selection</i> [25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare]] <i>OR</i> [\$1-100 per trip deductible then 25-100% of the amount approved by Medicare but not paid by Medicare]]
[Laboratory, Radiology Services and Advanced Radiological Imaging (includes diagnostic tests, pre-admission testing MRIs, MRAs, CAT Scans and PET Scans)		
Physician's Office	Not Applicable	<i>Choose based on plan selection</i> [25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare] <i>OR</i> [\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare]
Outpatient Hospital Facility <i>Include the following for Benefit Deductible Plan design-non-surgical facility</i>	Not Applicable	<i>Choose based on plan selection</i> [25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare] <i>OR</i> [\$1-150 per visit deductible/copayment then 25-100% of the amount approved by Medicare but not paid by Medicare]
Independent X-ray and/or Lab Facility]	Not Applicable	[25-100% <i>after plan deductible</i>] of the amount approved by Medicare but not paid by Medicare]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] Remove column when Part B expenses are not covered under the plan design.
<p>[Outpatient Short-Term Rehabilitative Therapy and Chiropractic Care Services]</p> <p>Maximum: Unlimited up to Medicare limits</p> <p>Includes:</p> <ul style="list-style-type: none"> Physical Therapy Speech Therapy Occupational Therapy Chiropractic Therapy (includes Chiropractors) Pulmonary Rehab Cognitive Therapy Cardiac Rehab] 	Not Applicable	<p>Choose based on plan selection</p> <p>[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]]</p> <p>OR</p> <p>[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare]]</p>
<p>Outpatient Short-Term Rehabilitative Therapy (above Medicare limits)</p> <p>Buy Up: Use the following box in addition to the standard Outpatient Short-Term Rehabilitative Therapy box when the buy up is elected.</p>		
<p>[Outpatient Short-Term Rehabilitative Therapy (above Medicare limits)]</p> <p>Maximum: Unlimited</p> <p>Includes:</p> <ul style="list-style-type: none"> Physical Therapy Speech Therapy Occupational Therapy Pulmonary Therapy Cognitive Therapy 	Not Applicable	<p>Choose based on plan selection</p> <p>[25-100% after plan deductible up to the Maximum Reimbursable Charge]]</p> <p>OR</p> <p>[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25- 100% up to the Maximum Reimbursable Charge]]</p>
<p>[Home Health Care (includes private duty nursing)</p> <p>Maximum: Unlimited</p>	Not covered by plan. Medicare pays in full	[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare]
[Maternity Care Services]		
<p>Initial Visit to Confirm Pregnancy</p> <p>Note: OB/GYNs are considered Specialists</p>	Not Applicable	<p>Choose based on plan selection</p> <p>[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]</p> <p>OR</p> <p>[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare]</p>

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Not Applicable	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Office Visits in addition to the global maternity fee when performed by an OB/GYN or specialist	Not Applicable	<i>Choose based on plan selection</i> [25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare] OR [\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare]
Delivery - Facility (Inpatient Hospital) (Birthing Center)	Same as plan's Inpatient Hospital Facility benefit Not Applicable	Not Applicable Same as plan's Outpatient Surgical Facility benefit[]
[Abortion] Includes non-elective procedures only		
Physician's Office Visit	Not Applicable	<i>Choose based on plan selection</i> [25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare] OR [\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare]
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Not Applicable
Outpatient Facility	Not Applicable	Same as plan's Outpatient Facility benefit
Inpatient Physician's Services	Not Applicable	[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare
Outpatient Physician's Services]	Not Applicable	[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
[Family Planning Services		
Surgical Sterilization Procedure for Vasectomy/Tubal Ligation Limited to Medicare covered services (excludes reversals)		
Physician's Office	Not Applicable	<i>Choose based on plan selection</i> [25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare] OR [\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare]
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Not Applicable
Outpatient Facility	Not Applicable	Same as plan's Outpatient Facility benefit
Inpatient Physician's Services	Not Applicable	[25-100% <i>after plan deductible</i>] of the amount approved by Medicare but not paid by Medicare
Outpatient Physician's Services]	Not Applicable	[25-100% <i>after plan deductible</i>] of the amount approved by Medicare but not paid by Medicare]
[Infertility Treatment Services Not Covered include: <ul style="list-style-type: none"> • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant are (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not Applicable	Not Covered]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
[Organ Transplants] Includes all medically appropriate, non-experimental transplants		
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Not Applicable
Inpatient Physician's Services	Not Applicable	[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare
Outpatient Physician's Services	Not Applicable	[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare
Travel Services	Not Covered	Not Covered]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
[Durable Medical Equipment Maximum: Unlimited	Not Applicable	[25-100% <i>after plan deductible</i>] of the amount approved by Medicare but not paid by Medicare]
[External Prosthetic Appliances Maximum: Unlimited	Not Applicable	[25-100% <i>after plan deductible</i>] of the amount approved by Medicare but not paid by Medicare]
[Diabetic Supplies and Services	Not Applicable	[25-100% <i>after plan deductible</i>] of the amount approved by Medicare but not paid by Medicare]
[Clinical Trials		
Physician's Office Visit	Not Applicable	<i>Choose based on plan selection</i> [25-100% <i>after plan deductible</i> of the amount approved by Medicare but not paid by Medicare] <i>OR</i> [\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare]
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Not Applicable
Outpatient Facility	Not Applicable	Same as plan's Outpatient Facility benefit
Inpatient Physician's Services	Not Applicable	[25-100% <i>after plan deductible</i>]of the amount approved by Medicare but not paid by Medicare
Outpatient Physician's Services	Not Applicable	[25-100% <i>after plan deductible</i>] of the amount approved by Medicare but not paid by Medicare]
[Dental Care Limited to Medicare covered dental services		

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
Physician's Office Visit	Not Applicable	<i>Choose based on plan selection</i> [25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare] OR [\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare]
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Not Applicable
Outpatient Surgical Facility	Not Applicable	Same as plan's Outpatient Surgical Facility benefit
Physician's Services	Not Applicable	[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare]
[TMJ Surgical and Non-surgical	Not Covered	Not Covered]
[Routine Foot Disorders Includes only services associated with foot care for diabetes and peripheral vascular disease.	Not Applicable	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]] OR [\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare]]
[Blood First 3 pints in a calendar year	Not Applicable	[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare
Additional amounts per calendar year	Not Applicable	[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare]
[Part B Covered Prescription Drugs	Not Applicable	[25-100% after plan deductible] of the amount approved by Medicare but not paid by Medicare]
[Smoking Cessation Counseling	Not Applicable	100% of the amount approved by Medicare but not paid by Medicare]
[Mental Health and Substance Abuse		

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
Inpatient <i>Federal parity-limit is permitted only if the hospital buy-up is not selected.</i> [Psychiatric Hospital Lifetime Maximum: 190 days]	Same as plan's Inpatient Hospital Facility benefit	Not Applicable
<i>Use the following box for Coinsurance Plan design</i>		
[Outpatient	Not Applicable	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]]
<i>Use the following box for Benefit Deductible Plan design</i>		
[Outpatient		
Individual Therapy	Not Applicable	<i>Choose based on plan selection</i> [25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare] OR [\$1-150 PCP per office visit deductible/copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare] OR [\$1-150 per office visit deductible/copayment then 25- 100% of the amount approved by Medicare but not paid by Medicare]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
Group Therapy	Not Applicable	<p><i>Choose based on plan selection</i></p> <p>[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]]</p> <p>OR</p> <p>[\$1-150 PCP per office visit deductible/copayment then 25-100% of the amount approved by Medicare but not paid by Medicare]]</p> <p>OR</p> <p>[\$1-150 per office visit deductible/copayment then 25-100% of the amount approved by Medicare but not paid by Medicare]]</p>
<i>At Home Recovery – Include the following if the Buy-up for At Home Recovery is selected</i>		
<p>[At Home Recovery</p> <p>Non Medicare covered home health activities to assist with daily living during recovery from an illness, injury or surgery (these visits have to follow Medicare approved/covered home health visits)</p>		
<p>Benefit for each visit:</p> <p>[[Contract] [Calendar] Year Maximum: \$ 500-unlimited]</p>	Not Applicable	[\$1-40] per visit]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<i>Foreign Travel – Include the following if Buy-up is selected.</i>		
<p>[Foreign Travel]</p> <p>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:</p> <p><i>include only when separate deductible is elected</i></p> <p>[[Calendar Year][Contract Year] deductible: \$ 1-250]</p> <p>[Lifetime Maximum: \$5,000-unlimited]</p>	Not Applicable	<p><i>Choose based on election</i></p> <p>[25-100% after plan deductible]]</p> <p>OR</p> <p>[25-100% after foreign travel deductible]]</p>
<i>Include the following if Hearing Buy-up is selected.</i>		
<p>[Routine Hearing Exam]</p> <p>Contract/Calendar Year</p> <p>[Maximum: 1 routine exam per year]</p>	Not Applicable	<p>[25-100% after plan deductible up to the Maximum Reimbursable Charge]]</p> <p>OR</p> <p>[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25- 100% up to the Maximum Reimbursable Charge]]</p>

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 Medicare or CIGNA.

Any applicable Deductibles or limits are shown in The Schedule.

Covered Expenses

Add text if policyholder selects coverage for Medicare Part A for the first 60 days per benefit period

- [charges made by a Hospital for Part A Medicare Eligible Expenses for a Hospital Confinement from the first day through the 60th day in any Medicare Benefit Period (Medicare Part A Deductible).]

Add text if policyholder selects coverage for Medicare part A for the first day through the 150th day per benefit period while using 60 lifetime reserve days

- [charges made by a Hospital for Part A Medicare Eligible Expenses for a Hospital Confinement from the first day through the 150th day in any Medicare Benefit Period (includes 60 lifetime reserve days).]

Add text if policyholder selects coverage for Medicare Part A for the 61st day through the 150th day per benefit period while using 60 lifetime reserve days

- [charges made by a Hospital for Part A Medicare Eligible Expenses for a Hospital Confinement from the 61st day through the 150th day in any Medicare Benefit Period (includes 60 lifetime reserve days).]

Add text if buy up for Inpatient Hospital-Facility Services is elected for an additional 365 days once lifetime reserve days are used

- [charges made by a Hospital for a Hospital Confinement for an additional 365 days per benefit period per person per lifetime once the lifetime reserve days are used (or would have ended if used).]

Covered Expenses (continued)

- charges made by a Skilled Nursing Facility, rehabilitation hospital and sub-acute facilities for Part A Medicare Eligible Expenses from the 21st day through the 100th day in any Medicare Benefit Period. A person must have been in the Hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the Hospital.

Add text for buy-up for Inpatient services at Other Health Care Facilities for coverage from the 101st day through the 365th day

- [charges made by a Skilled Nursing Facility from the 101st day through 365th day (days in excess of those covered by Medicare). A person must have been in the Hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the Hospital.]

Add text for buy-up for Inpatient services at Other Health Care Facilities for coverage from the 101st day through the 120th day

- [charges made by a Skilled Nursing Facility from the 101st day through 120th day (days in excess of those covered by Medicare). A person must have been in the Hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the Hospital.]

Add text for buy-up for Inpatient services at Other Health Care Facilities for coverage from the 101st day through the 180th day

- [charges made by a Skilled Nursing Facility from the 101st day through 180th day (days in excess of those covered by Medicare). A person must have been in the Hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the Hospital.]

Add text for Hospice/Inpatient Respite Care, including bereavement counseling

- [charges made for Hospice/Inpatient Respite Care for Part A Medicare Eligible Expenses which includes bereavement counseling for a terminally ill person.]

Add text if policyholder selects Medicare Part B Deductible coverage.

- [charges made for the Medicare Part B Deductible.]

Covered Expenses (Continued)

Add text if policyholder selects remainder of Part B expenses.

- [charges made for the Medicare Approved Amounts remaining for Part B Medicare Eligible Expenses including but not limited to:
 - charges made for Inpatient and Outpatient Physicians services.
 - charges made for laboratory and radiology services.
 - charges for Medicare Eligible Expenses for preventive care for an annual routine physical and a one time "Welcome to Medicare" exam.
 - charges made for immunizations.
 - charges for the following Early Cancer Detection Screenings including but not limited to:
 - pap test and pelvic examination;
 - prostate cancer screening and digital exam;
 - mammogram screening;
 - colonoscopy ;
 - sigmoidoscopy;
 - fecal blood test; and
 - barium enema.
 - charges made for the first 3 pints of blood in a calendar year or equivalent quantities of packed red blood cells as defined under federal regulations unless replaced in accordance with federal regulations.
 - charges made for additional amounts of blood after the first 3 pints in a calendar year.
 - charges made for outpatient short-term rehabilitative therapy.
 - charges made for home health care services.
 - charges made for maternity.
 - charges made for family planning surgical related services.
 - charges made for durable medical equipment and external prosthetic appliances.
 - charges made for diabetic supplies, including but not limited to: blood glucose test strips, blood glucose monitor, lancet devices and lancets, glucose control solutions for checking accuracy of test strips and monitors and therapeutic shoes or inserts.
 - charges made for clinical trials.

Covered Expenses (Continued)

- charges made in an outpatient facility, emergency room or urgent care facility.
- charges made for ambulance services.
- charges made for routine foot disorders for diabetes and peripheral vascular disease when Medically Necessary.
- charges made for prescription drugs including but not limited to: antigens, osteoporosis drugs, erythropoiesis, blood clotting factors, injectable drugs, immunosuppressive drugs, oral cancer drugs, and oral anti-nausea drugs.
- charges for smoking cessation counseling.
- charges made for mental health and substance abuse.
- charges made for organ transplants.
- charges made for dental care.]

Add text if policyholder selects buy-up for At Home Recovery Benefits

- [charges made for At Home Recovery Services when a) you require assistance with activities of daily living during recovery from an illness, injury, or surgery; b) the total number of at-home recovery visits do not exceed the total number of Medicare-covered Home Care visits for this illness, injury, or surgery; c) the at-home recovery visits are received within eight weeks following the date of the last home visit that is covered by Medicare.]

Add text if policyholder selects buy-up for Foreign Travel Emergency Services

- [charges made for any Foreign Travel Emergency Services deductible and for the charges remaining after any such deductible. Covered Expenses will include any Emergency Services that begin within the first 60 days of travel outside the United States in a year.]

Add text if policyholder selects buy-up for Part B excess charges above approved Medicare amounts

- [Part B Excess charges for providers who do not accept Medicare assignment after any Medicare Part B Deductible is met. Coverage will be provided for the difference between the actual Medicare Part B charge as billed and the Medicare approved Part B charge.]

Add text if policyholder selects buy-up for routine hearing exam.

- [charges made for a routine hearing exam.]

Add text if policyholder selects buy-up for Short-term Rehabilitation

- [charges made for outpatient short-term rehabilitative therapy above Medicare limits.]

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Exclusions

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

- any expense that is:
 - a. Not a Medicare Eligible Expense; or
 - b. beyond the limits imposed by Medicare for such expense; or
 - c. excluded by name or specific description by Medicare; except as specifically provided under the “Covered Expenses” section or any other portion of this certificate including any riders attached.
- any portion of a Covered Expense to the extent paid or payable by Medicare;
- any benefits payable under one benefit of this plan to the extent payable under another benefit of this plan;
- Covered Expenses Incurred after coverage terminates;

Add text when buy-ups are elected. Exclusions may be included or omitted.

[In addition, the following exclusions apply to any service that is a Covered Expense under this plan, but is not covered by Medicare

- 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.

Exclusions (continued)

- 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.
- 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.
- 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.
- blood administration for the purpose of general improvement in physical condition.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- massage therapy.]

Limitations may be included or omitted

General Limitations

- [charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- 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.

Add exclusion when foreign travel benefit is elected.

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

PAYMENT OF BENEFITS

To Whom Payable

Medical Benefits are assignable to the provider if the provider does not participate with Medicare. 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. All claims for providers that participate with Medicare will be assigned to the provider.

CIGNA may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Medicare Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of CIGNA, is not able to give a valid receipt for any payment due 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: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) 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.]

TERMINATION OF INSURANCE

Eligible Persons

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Persons or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.

Include text when dependent coverage is included. Include variable text when Family Security Benefit is selected.

[Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases[except when you die].
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.]

DEFINITIONS

[Dependent

Dependents are:

- your lawful spouse who is eligible for Medicare; [and]

Add text if Domestic Partner coverage is included.

- [your Domestic Partner who is eligible for Medicare; and]
- [any unmarried child of yours who is eligible for Medicare by reason of disability who is:
 - 18 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CIGNA within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, CIGNA 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 who is eligible for Medicare by reason of disability. It also includes a stepchild who lives with you.

Add text if Domestic Partner coverage is included.

[If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent if they are eligible for Medicare.]

No one will be considered as a Dependent of more than one Eligible Person.]

DEFINITIONS

Eligible Person

The term Eligible Person means a [former employee, a retiree or terminated employee of the Employer] who is eligible for Medicare by reason of age or disability.

DEFINITIONS

[Hospice Care Services

The term Hospice Care Services means any Medicare Eligible Expenses provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a home health care agency, (d) a hospice facility, or (e) any other licensed facility or agency under a hospice care program.]

DEFINITIONS

Hospital

[The term Hospital means:

- an institution that is approved by Medicare and has agreed to participate in Medicare.
- An institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) 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: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

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

DEFINITIONS

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.

DEFINITIONS

Medicare Approved Amount

The term Medicare Approved Amount means the amount in the Original Medicare Plan that a Physician or supplier can be paid, including what Medicare pays and any deductible, coinsurance or co-payment that you pay. It may be less than the actual amount charged by a Physician or supplier.

DEFINITIONS

Medicare Eligible Expenses

The term Medicare Eligible Expenses means expenses covered by Medicare to the extent recognized as reasonable by Medicare.

DEFINITIONS

Medicare Part A Benefit Period

The term Medicare Part A Benefit Period means a period of time during which a Medicare beneficiary is Hospital or Skilled Nursing Facility confined. A Medicare Benefit Period:

- a. begins when a Medicare beneficiary is admitted to a Hospital as an inpatient; and
- b. ends when he or she has not been Confined in a Hospital or Skilled Nursing Facility for [60 consecutive days.]

DEFINITIONS

Medicare Part A Deductible

Medicare Part A Deductible means the deductible amount that you are required to pay under Medicare for expenses incurred at the beginning of a Medicare Part A Benefit Period.

DEFINITIONS

[Medicare Part B Deductible

Medicare Part B Deductible means the deductible amount that you are required to pay under Medicare Part B each calendar year for Medicare Eligible Expenses.]

DEFINITIONS

Original Medicare Plan

The Original Medicare Plan means a fee-for-service health plan that lets you go to any Physician, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare Approved Amount, and you pay your share (coinsurance). In some cases you may be charged more than the Medicare Approved Amount. The Original Medicare Plan has Part A (Hospital Insurance) and Part B (Medical Insurance).

DEFINITIONS

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.

A Physician may be either a Participating Physician or Non-Participating Physician. A Participating Physician is one who has agreed in advance to accept Medicare assignments for claims. The amount the Physician can charge is limited to the Medicare Approved Amount. A non-Participating Physician has not agreed to accept Medicare assignment and may charge more than the Medicare Approved Amount

DEFINITIONS

[Related Plan

The term Related Plan means the Policyholder's employee health plan.]

DEFINITIONS

Sickness

The term Sickness means a physical illness. This includes mental illness and substance abuse.

DEFINITIONS

[Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which meets all of the conditions required in order to be eligible for payment as a skilled nursing facility under Medicare.]

**CIGNA HEALTH AND LIFE INSURANCE COMPANY
a CIGNA COMPANY (hereinafter called CIGNA)**

CERTIFICATE RIDER

You will become insured on the date you become eligible, if you are in a class of Eligible Persons on that date.

This certificate rider forms a part of the certificate issued to you by CIGNA describing the benefits provided under the policy(ies) specified in the certificate.

The provisions set forth in this certificate rider comply with legislative requirements of Arkansas. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following is added to the medical section of your certificate entitled "Covered Expenses:"

Remove bullet for Part A only rider.

- coverage for Medically Necessary equipment, services, and supplies when prescribed by a Physician and administered by a licensed health care professional, for the treatment of Type I, Type II, and gestational diabetes. Coverage includes one self-management training program per lifetime per insured; and additional training due to a significant change in symptoms or condition.

Remove bullet for Part A only rider.

- charges made for anesthesia, hospitalization services and/or ambulatory surgical facility charges performed in connection with dental procedures when such services are required to effectively perform the procedures and the patient is: (a) under seven years of age and it is determined by two dentists that treatment in a hospital or ambulatory surgical center is required without delay due to a significantly complex dental condition; (b) a person with a serious diagnosed mental or physical condition; or (c) a person with a significant behavioral problem as determined by their physician.

Remove bullet for Part A only rider.

- charges for prostate cancer examinations and laboratory tests for any non-symptomatic man forty years of age or older in accordance with the National Comprehensive Cancer Guidelines.

Remove bullet for Part A only rider.

- charges for colorectal cancer examinations and laboratory tests for covered person who: (a) are fifty years of age or older; (b) are less than fifty years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; or (c) are experiencing the following symptoms of colorectal cancer as determined by a physician: bleeding from the rectum or blood in the stool; or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five days.

The colorectal screening shall involve an examination of the entire colon, including the following examinations and laboratory tests: (a) an annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five years; (b) a double-contrast barium enema every five years; or (c) a colonoscopy every ten years; and any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, as determined in consultation with appropriate health care organizations.

Remove bullet for Part A only rider.

- charges, to the extent covered by Medicare, for a drug that has been prescribed for the treatment of cancer for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be covered, provided: (a) the drug is recognized for the specific cancer treatment for which the drug has been prescribed in any one of the following established reference compendia: United States Pharmacopeia Drug Information; American Medical Association Drug Evaluation; American Hospital Formulary Service; or two articles from major peer-reviewed medical journals not contradicted by data in another article from such a journal; (b) the drug has been otherwise approved by the FDA; and (c) its use for the specific type of cancer treatment prescribed has not been contraindicated by the FDA for the use prescribed.

Remove bullet for Part A only rider.

- Charges for the necessary care and treatment of loss or impairment of speech or hearing by a licensed audiologist or speech pathologist.

Remove bullet for Part A only rider.

- Charges for hearing aids in an amount of not less than \$1,400 per ear every three years; and for other purposes.

Hearing aid means an instrument or device, including repair and replacement parts, that is: (a) designed and offered for the purpose of aiding persons with or compensating for impaired hearing; (b) worn in or on the body; and (c) generally not useful to a person in the absence of hearing impairment. Such coverage is not subject to deductibles or copayment requirements.

Remove bullet for Part A only rider.

- charges for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed under the direction of a Physician for the Medically Necessary treatment of phenylketonuria (PKU).
- charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) 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.

Infertility Services

- charges made for services related to diagnosis and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; cryopreservation of donor sperm and eggs sperm washing or preparation; and diagnostic evaluations.

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility. The following are specifically excluded infertility services:

- Infertility drugs;
- In vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;
- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Donor charges and services;
- Any experimental, investigational or unproven infertility procedures or therapies.

The following is added to the Definitions section of your certificate:

Dependent

Dependents are:

- your lawful spouse who is entitled to Medicare;
- the lawful spouse of an Under age 65 retiree who is entitled to Medicare;
- your Domestic Partner who is entitled to Medicare; and
- any unmarried child of yours who is entitled to Medicare by reason of disability who is:
 - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CIGNA after the date the child ceases to qualify above.

The term child means a child born to you, a child legally adopted by you. It also includes a stepchild who lives with you. If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day of the calendar month in which the dependent child is no longer entitled to Medicare by reason of disability.

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

The following is added to your certificate:

THE FOLLOWING WILL APPLY TO RESIDENTS OF ARKANSAS

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

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

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

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can 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 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 to register your appeal by telephone. Call or write to us at the toll-free number or address 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 (decision). We will respond 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 function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves 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, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

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

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by CIGNA's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working 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, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves 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, we 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, certain conditions apply. 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 condition, as determined by CIGNA's Physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by CIGNA.

Appeal to the State of Arkansas

You have the right to contact the Arkansas Insurance Department for assistance at any time. The Consumer Services Division may be contacted at the following address and telephone number:

Arkansas Insurance Department, Consumer Services Division
Third and Cross Streets, Little Rock, AR 72201
501-371-2640

501-371-2749 Fax
or call: 1-800-852-5494

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

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

You may also contact the Plan Administrator.

Relevant Information

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CIGNA until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

Remove bullet for Part A only rider.

SERFF Tracking Number: CCGH-126875476 State: Arkansas
 Filing Company: CIGNA Health and Life Insurance Company State Tracking Number: 47225
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002C Large Group Only - Other
 Product Name: Group Medical Retiree Plan
 Project Name/Number: /CCGH-126875476

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/19/2010
Comments:			
Attachment:			
	AR Certification.pdf		

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/19/2010
Bypass Reason:	n/a		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/19/2010
Comments:	This filings are not subject to PPACA because PPACA is not applicable to retiree plans.		

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved-Closed	11/19/2010
Comments:			
Attachment:			
	Statement of Variability for Medicare Surround.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Forms Listing	Approved-Closed	11/19/2010
Comments:			
Attachment:			

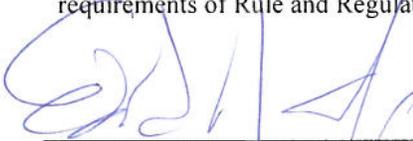
SERFF Tracking Number: *CCGH-126875476* *State:* *Arkansas*
Filing Company: *CIGNA Health and Life Insurance Company* *State Tracking Number:* *47225*
Company Tracking Number:
TOI: *H16G Group Health - Major Medical* *Sub-TOI:* *H16G.002C Large Group Only - Other*
Product Name: *Group Medical Retiree Plan*
Project Name/Number: */CCGH-126875476*
AR SERFF - CHLIC Medicare Surround Forms Listing.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: CIGNA Health and Life Insurance Company

Form Number(s): HC-SPP et al

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Edmund J. Skowronek, Jr.

Name

Director

Title

November 1, 2010

Date

CIGNA Health and Life Insurance Company

Statement of Variability Forms HC-SPP9 et. al.

General

1. To the extent that variable changes are made they will not be ambiguous or deceptive.
2. Titles or names such as Product Name may change but their relation to the matter to which they pertain will not be ambiguous or deceptive.
3. Connective words and phrases that only serve the grammatical purpose of meaningful continuity may vary as the sense demands.
4. Text may be varied to include text that is approved by your Department for use with CIGNA medical plans.
5. Text may vary in accordance with changes in Medicare.
6. Wording may vary in order to facilitate and/or to clarify the meaning of terms and benefits conveyed in the coverage. Examples of such changes include but are not limited to:
 - benefit provisions may be re-written at the request of our customers to clarify the policyholder's understanding of benefits and/or administration.

CIGNA Health and Life Insurance Company

Listing of Forms Submitted for Approval

Certificate Forms

HC-SPP9	Additional Programs
HC-IMP75	Important Notices
HC-CLM17	How to File Your Claim
HC-ELG38.....	Eligibility – Effective Date
HC-SOC149.....	Schedule of Insurance
HC-COV177	Covered Expenses
HC-EXC55.....	Exclusions, Expenses Not Covered and General Limitations
HC-POB31	Payment of Benefits
HC-TRM75	Termination of Insurance
HC-DFS373	Dependent
HC-DFS374	Eligible Person
HC-DFS375	Hospice Care Services
HC-DFS376	Hospital
HC-DFS377	Hospital Confinement Or Confined In A Hospital
HC-DFS378	Medicare Approved Amount
HC-DFS379	Medicare Eligible Expenses
HC-DFS380	Medicare Part A Benefit Period
HC-DFS381	Medicare Part A Deductible
HC-DFS382	Medicare Part B Deductible
HC-DFS383	Original Medicare Plan
HC-DFS384	Physician
HC-DFS385	Related Plan
HC-DFS386	Sickness
HC-DFS387	Skilled Nursing Facility
HC-RDR21	Legislation Rider