Cigna HealthCare of Texas, Inc. ("Cigna")

INDIVIDUAL AND FAMILY EVIDENCE OF COVERAGE (EOC)

Cigna Connect Flex Silver 5000-200 Plan

THIS PLAN MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Plan was issued to You by Cigna HealthCare of Texas, Inc. based on the information You provided in Your application, a copy of which is attached to the Plan. If You know of any misstatement in Your application, You should advise Us immediately regarding the incorrect information; otherwise, Your Plan may not be a valid contract.

Direct Access to Obstetricians and Gynecologists (OB/GYN)

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact Customer Service at the phone number listed on the back of Your ID card.

Selection of a Primary Care Provider

This plan allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept You or Your family members. If Your plan requires the designation of a primary care provider, Cigna may designate one for You until You make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact Customer Service at the phone number listed on the back of Your ID card.

For children, You may designate a pediatrician as the Primary Care Physician.

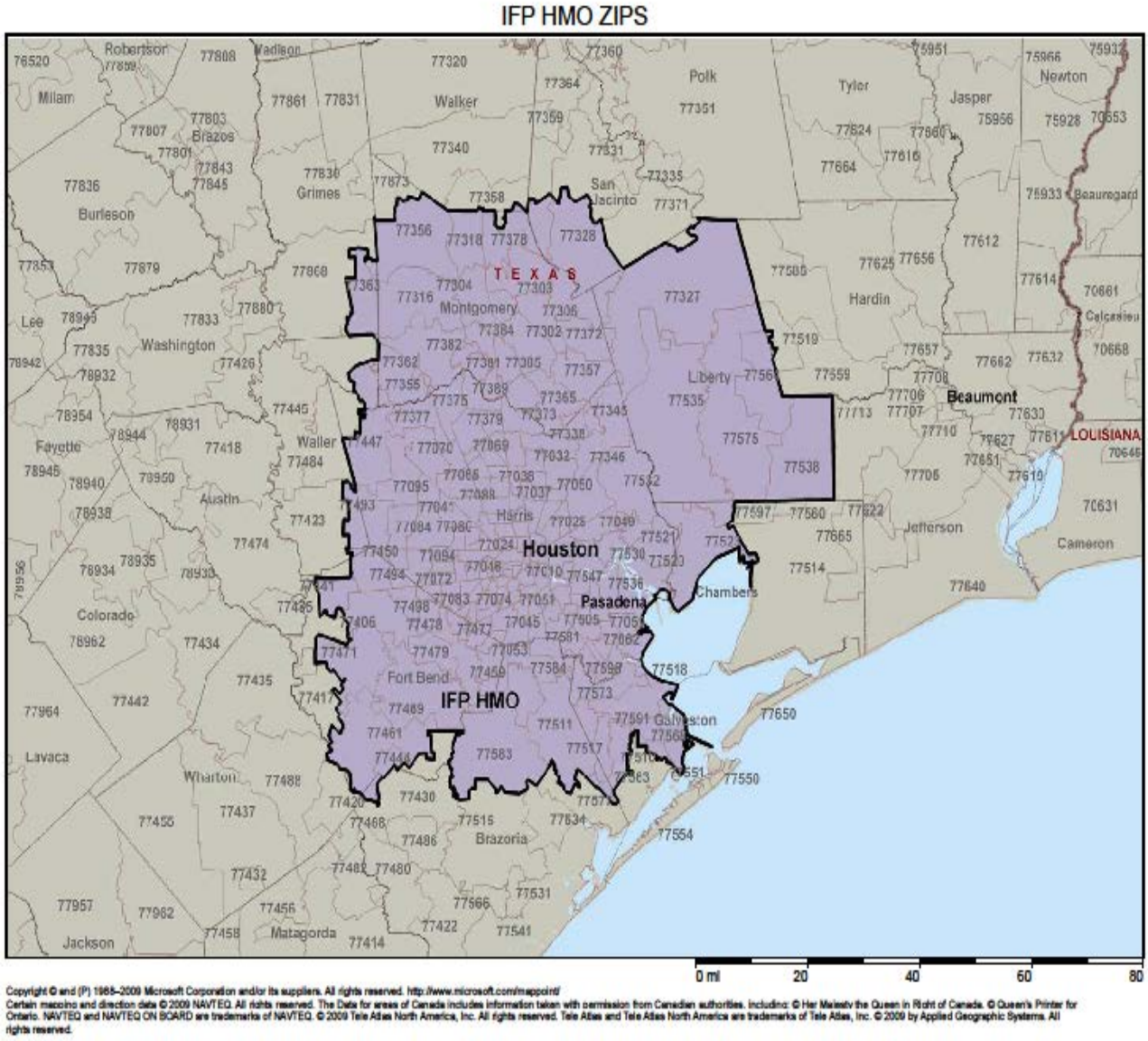
THIS EVIDENCE OF COVERAGE (EOC) IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

If You wish to correspond with Us for any reason, write:

Cigna
Individual Services
P. O. Box 30365
Tampa, FL 33630-3365
1-877-484-5967

Include Your Cigna identification number with any correspondence. This number can be found on Your Cigna identification card.

HMO Service Area Map



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To obtain information or make a complaint:	**Para obtener informacion o para presentar una queja:**
You may contact your Cigna Health Care of Texas at: **1-877-484-5962**	**Usted pude comunicarse con su Cigna Health Care of Texas al:** **1-877-484-5962**
You may call Cigna Health Care of Texas' toll-free telephone number for information or to make a complaint at **1-877-484-5962**	**Usted puede llamar al numero de telefono gratuito de Cigna Health Care of Texas para obtener informacion o para presentar una queja al** **1-877-484-5962**
You may also write to Cigna Health Care of Texas at: **Cigna Health Care of Texas** **PO Box 30365** **Tampa FL 33630-3365**	**Usted tambien puede escribir a Cigna Health Care of Texas al:** **Cigna Health Care of Texas** **PO Box 30365** **Tampa FL 33630-3365**
You may contact the Texas Department of Insurance to obtain information on companies, coverage's, rights or complaints at **1-800-252-3439**	**Usted puede comunicarse con el Departamento de Seguros de Texas para obtener informacion sobre companias, coberturas, derechos, o quejas al:** **1-800-252-3439**
You may write the Texas Department of Insurance: **P.O. Box 149104** **Austin TX 78714-9104** **Fax : (512) 490-1007** **Web:** http://www.tdi.texas.gov **E-mail: ConsumerProtection@tdi.texas.gov**	**Usted puede escribir al Departamento de Seguros de Texas a:** **P.O. Box 149104** **Austin TX 78714-9104** **Fax : (512) 490-1007** **Sitio web:** http://www.tdi.texas.gov **E-mail: ConsumerProtection@tdi.texas.gov**
ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.	**ADJUNTE ESTE AVISO A SU POLIZA:** Este aviso es solamente para propositos informativos y no se convierte en parte o en condicion del documento adjunto.

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INTRODUCTION

This Agreement is a legal contract between You as the Subscriber, and Cigna HealthCare of Texas, Inc. (Cigna).

The benefits of this Plan are provided only for those services that are Medically Necessary as defined in this Plan and for which the Member has benefits. The fact that a Physician prescribes or orders a service does not, in itself, mean that the service is Medically Necessary or that the service is a Covered Service. Consult this Plan or phone Us at the number shown on Your Cigna identification card if You have any questions regarding whether services are covered.

This Plan contains many important terms (such as “Medically Necessary” and “Covered Service”) that are defined in the section entitled “Definitions". Before reading through this Plan, be sure that You understand the meanings of these words as they pertain to this Plan.

We provide coverage to You under this Plan based upon the answers submitted by You and Your Dependent(s) on Your signed individual application. In consideration for the payment of the premiums stated in this Plan, We will provide the services and benefits listed in this Plan to You and Your Dependent(s) covered under the Plan.

IF, WITHIN 2 YEARS AFTER THE EFFECTIVE DATE OF YOUR PARTICIPATION IN THE PLAN, WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED, OMITTED OR THAT YOU OR YOUR DEPENDENT (S) KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND THIS COVERAGE AS OF THE ORIGINAL EFFECTIVE DATE. ADDITIONALLY, IF WITHIN 2 YEARS AFTER ADDING ADDITIONAL DEPENDENT(S) (EXCLUDING NEWBORN CHILDREN OF THE SUBSCRIBER ADDED WITHIN 31 DAYS AFTER BIRTH), WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED, OMITTED OR THAT YOU OR YOUR DEPENDENT(S) KNEW BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND COVERAGE FOR THE ADDITIONAL DEPENDENT (S) AS OF THE DATE HE OR SHE ORIGINALLY BECAME EFFECTIVE. **IF WE RESCIND YOUR COVERAGE, WE WILL PROVIDE YOU WITH 30 DAYS ADVANCE NOTICE AND WE WILL REFUND ALL PREMIUMS YOU PAID FOR YOUR PLAN LESS THE AMOUNT OF ANY CLAIMS PAID BY CIGNA. RESCISSION OF YOUR COVERAGE WILL RESULT IN DENIAL OF ALL PENDING CLAIMS AND, IF CLAIM PAYMENTS EXCEEDS TOTAL PREMIUM PAID, THEN CLAIMS PREVIOUSLY PAID BY CIGNA WILL BE RETROACTIVELY DENIED, OBLIGATING YOU TO PAY THE PROVIDER IN FULL FOR SERVICES RENDERED AT THE PROVIDER'S REGULAR BILLED RATE, NOT AT THE CIGNA CONTRACT ALLOWANCE.**

RIGHT TO RETURN CONTRACT

If You are not satisfied, for any reason, with the terms of this Plan You may return it to Us within 10 days of receipt. We will then cancel Your coverage as of the original Effective Date and promptly refund any premium You have paid. This Plan will then be null and void. However, if services are rendered or claims paid by the Cigna during the 10 days, the Subscriber is responsible for repaying the Us for such services or claims.

SERVICE AREA RESTRICTIONS

This Plan includes a Service Area restriction which requires that all Members receive services in the defined service area. Coverage outside of the defined Service Area is limited to Emergency Services and Emergency Medical Treatment only.

ROLE OF THE PRIMARY CARE PHYSICIAN

Establishment of the Physician-Patient Relationship

By enrolling, You are choosing to have services and benefits under the "Services and Benefits" Section provided by, or arranged for by, a Primary Care Physician. The Primary Care Physician maintains the physician-patient relationship with Members who select him or her as their Primary Care Physician. The Primary Care Physician is responsible to Cigna for providing and/or coordinating Medical Services and Hospital Services for overall health care needs of such Members.

Choosing a Primary Care Physician

When You enroll as a Member, You must choose a Primary Care Physician (PCP). Each covered Member of Your family also must choose a PCP. If You do not select a PCP, we will assign one for You. If Your PCP ceases to be a Participating Physician, You will be able to choose a new PCP. You may voluntarily change Your PCP for other reasons but not more than once in any calendar month. We reserve the right to determine the number of times during a Plan Year that You will be allowed to change Your PCP. If You select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following Your selection. If You select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example, if You notify us on June 10, the change will be effective on July 1. If You notify us on June 15, the change will be effective on August 1.

Your choice of a PCP may affect the specialists and facilities from which You may receive services. Your choice of a specialist may be limited to specialists in Your PCP's medical group or network including a Limited Network. Therefore, You may not have access to every specialist or Participating Provider in Your Service Area. Before You select a PCP, You should check to see if that PCP is associated with the specialist or facility You prefer to use. If the Referral is not possible, You should ask the specialist or facility about which PCPs can make Referrals to them, and then verify the information with the PCP before making Your selection.

Designation of a Specialist as Primary Care Physician

If You have a chronic, disabling or life-threatening Illness, You may apply to Cigna's Medical Director to allow You to designate Your treating specialist as Your Primary Care Physician. Your application must:

- include information specified by Cigna, including certification of the medical need; and
- be signed by You and Your treating specialist interested in serving as Your Primary Care Physician:

To be eligible to serve as Your Primary Care Physician, Your specialist must:

- meet Cigna's requirements for Primary Care Physician participation; and
- agree to accept the responsibility to coordinate all of Your health care needs:

If Cigna denies Your application to designate Your specialist as Your PCP, You can appeal that decision. Please refer to the section of this Plan titled "When You Have a Complaint or Appeal…" for instructions in how to appeal the decision.

If Cigna approves Your application to designate Your physician specialist as Your PCP, the effective date upon which the designated specialist becomes Your PCP must be effective as of the date of the approval or later.

Cigna may not reduce the amount of compensation owed to Your original PCP for services provided before the date the new designation was approved.

Referrals to Specialists

You must obtain a Referral from Your PCP before visiting any provider other than Your PCP in order for the visit to be covered. The Referral authorizes the specific number of visits that You may make to a provider within a specified period of time. If You receive treatment from a provider other than Your PCP without a Referral from Your PCP, the treatment is not covered.

Exceptions to the Referral process

If You are a female Member, You may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in “Covered Services and Supplies," without a Referral from Your PCP.

If You are a Member under age 19, You may visit a Network Dentist for Pediatric Dental Benefits or a Network Vision Provider for Pediatric Vision Benefits without a Referral from Your PCP.

You do not need a Referral from Your PCP for Emergency Services as defined in the “Definitions." In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or Your local emergency service, police or fire department for help. You do not need a Referral from Your PCP for Emergency Services, but You do need to call Your PCP as soon as possible for further assistance and advice on follow-up care.

In an emergency, You should seek immediate medical attention and then as soon as possible thereafter You need to call Your PCP for further assistance and advice on follow-up care.

In an Urgent Care situation a Referral is not required but You should, whenever possible, contact Your PCP for direction prior to receiving services.

You may also visit a qualified Participating Provider for covered Pediatric Vision Care Services and Pediatric Dental Care Services, as defined in “Covered Services and Supplies”, without a referral from Your PCP.

Standing Referral to Specialist

You may apply for a standing referral to a provider other than Your PCP when all of the following conditions apply:

1. You are a covered Member of the Cigna HMO Plan;
2. You have a disease or condition that is life threatening, degenerative, chronic or disabling;
3. Your PCP in conjunction with a Network Specialist determines that Your care requires another Provider’s expertise;
4. Your PCP determines that Your disease or condition will require ongoing medical care for an extended period of time;
5. The standing referral is made by Your PCP to a network specialist who will be responsible for providing and coordinating Your specialty care; and

6. The network specialist is authorized by Cigna to provide the services under the standing referral.

We may limit the number of visits and time period for which You may receive a standing referral. If You receive a standing referral or any other referral from Your PCP, that referral remains in effect even if the PCP ceases to be a Participating Physician. If the treating specialist leaves Cigna's network or You cease to be a covered Member, the standing referral expires.

Service by Non-Participating Providers/Network Exception

If You need Covered Services and Our Participating Provider network does not contain a Participating Provider with the specialty necessary to treat You, Your Primary Care Physician or Participating Physician may request a referral to a Non-Participating Provider:

- within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient,
- but in no event to exceed five (5) business days after receipt of reasonably requested documentation.

The Non-Participating Provider will be reimbursed at the Maximum Reimbursable Charge as defined in this Evidence of Coverage or at a rate agreed upon between Us and the Non-Participating Provider. The Cigna Medical Director has the right to refer You to a Non-Participating Provider of his or her choice or to deny the request for referral if he or she feels that the services can be adequately provided by a Participating Provider.

Prior to denying a request for referral to an Out-of-Network (Non-Participating) Provider, Cigna must provide for a review conducted by a Specialist of the same or similar type of specialty as the Physician or Provider to whom the Referral is requested.

Continuity of Care

If Your PCP or Network Specialist ceases to be a Participating Physician, We will notify You in writing of his or her impending termination and provide assistance in selecting a new PCP or identifying a new Network Specialist to continue providing Covered Services. If You are receiving treatment from a Participating Provider at the time his or her Participating Provider agreement is terminated, for reasons other than medical incompetence or professional misconduct, You may be eligible for continued care with Your Provider if Your treating Provider reasonably believes that discontinuing Your care with him or her may cause You harm. To be eligible for this continued care You must be receiving treatment in accordance with the dictates of medical prudence for one or more special circumstances, examples of which are:

(a) a disability;

(b) an acute condition;

(c) a life threatening illness or

(d) for pregnancy past the twenty fourth (24th) week.

You may continue care with the Provider as follows:

(a) for up to nine (9) months if you have been diagnosed with a terminal illness;

(b) through delivery of the child, including immediate postpartum care and a follow up checkup within the six (6) week period after delivery if you are past the twenty-fourth (24th) week of pregnancy; or

(c) for up to ninety (90) days after the effective date of the provider's termination.

Your Provider must identify Your special circumstance to the Cigna Medical Director and request that You continue under his or her care. Your Provider must agree not to seek payments from You except for Copayments and/or Percentage Copayments applicable for services rendered. The Cigna Medical Director may deny this request if he determines that Your treatment may be transferred to another Provider without causing You harm, or if he determines that the request is not Medically Necessary.

DEFINITIONS

Acceptable Third Party Payor means one or more of the following:

1. the Ryan White HIV/AIDS Program established under Title XXXVI of the Public Health Service Act;
2. an Indian tribe, tribal organization, or urban Indian organization;
3. a State or Federal government program; or
4. a private entity that (i) is organized as a not-for-profit organization under State law, (ii) has received a determination from the Internal Revenue Service that the entity qualifies for an exemption from federal income tax under 26 U.S.C. § 501(c)(3), and (iii) makes payments on Your behalf solely on the basis of Your financial need and does not in any way consider the health status of any Member in determining whether to make such payments on Your behalf.

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The Injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Agreement means the Cigna HealthCare of Texas, Inc. Individual Plan Evidence of Coverage (EOC), Specification Page, Schedule of Benefits, any Supplemental Riders and any other attachments described herein, the Enrollment Application, and any subsequent amendment or modification to any part of the Plan.

Annual Open Enrollment Period means the designated period of time during each Calendar Year when individuals can apply for coverage under this Plan for the following Year. The Annual Open Enrollment Period is set by the federal government, and the beginning and ending dates are subject to change each Year.

Autism Spectrum Disorders means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association: Autistic Disorder, Asperger's Syndrome, Pervasive Developmental Disorder - Not Otherwise Specified. A “Neurobiological disorder” means an Illness of the nervous system caused by genetic, metabolic or other biological factors.

Birthing Center means a licensed outpatient facility which provides accommodations for childbirth for low-risk maternity patients. The Birthing Center must meet all of the following criteria:

1. has an organized staff of certified midwives, Physicians, and other trained personnel;
2. has necessary medical equipment;
3. has a written agreement to transfer to a hospital if necessary; and
4. is in compliance with any applicable state or local regulations.

Brand Name Prescription Drug /Brand Name	means a Prescription Drug that has been patented and is produced by only one manufacturer.
Calendar Year /Year	means a 12-month period beginning each January 1 at 12:01 a.m. Eastern Time
Charges	means the actual billed Charges; except when the provider has contracted directly or indirectly with Cigna for a different amount.
Cigna	means Cigna HealthCare of Texas, Inc. a health maintenance organization (HMO) which is organized under the laws of the State of Texas. Cigna is a party to the Plan.
Cigna Medical Director	means a Physician or his designee charged with the direction and management of Participating Physicians.
Copayment	means a predetermined fee for physician office visits, prescriptions, hospital or other services that the Member pays at the time of service.
Cosmetic Surgery	means surgery that is performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance. **Cosmetic Surgery Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.**
Covered Expenses	means expenses that are incurred for Covered Services under this Plan and that Cigna will consider for payment under this Plan. Additionally, Covered Expenses may be limited by other specific maximums or terms described in this Plan. Covered Expenses are subject to any applicable Deductibles and any applicable benefit limits. An expense is incurred on the date the Member receives the service or supply for which a claim is made.
Covered Services/Supplies	means Medically Necessary services or supplies that are listed in the Schedule of Benefits and other sections of this Plan and that are not excluded by the Plan .

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

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

Days means calendar days unless expressly stated otherwise.

Deductible means a dollar amount that a Member pays before the Plan begins to pay toward the cost of covered medical expenses.

Dental Prostheses are dentures, crowns, caps, bridges, clasps, habit appliances, and partials.

Dependent means those individuals in the Subscriber's family who meet the eligibility requirements of the "Dependent" provision of the "Eligibility" Section and are enrolled under the Plan.

Diabetes Equipment includes, but is not limited to, blood glucose monitors, including monitors designed to be used by blind persons; insulin pumps and associated appurtenances, including insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices in the injection of insulin and any other required disposable supplies; podiatric appliances for the prevention of complications associated with diabetes; the repair or maintenance of insulin pumps not covered under a manufacturer's warranty and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

Diabetes Self-Management Training means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as means of avoiding frequent hospitalization and complications.

Diabetes Pharmaceuticals & Supplies

include, but are not limited to, blood glucose monitors on Cigna's Prescription Drug List; test strips for blood glucose monitors; visual reading and urine test strips; tablets that test for glucose; specific blood glucose monitors, ketones and protein; lancets and lancet devices; insulin and insulin analogs; injection aids, including devices used to assist with insulin injection and needleless systems; syringes and needles; biohazard disposal containers; prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits.

Diabetes New or Improved Equipment or Supplies

include improved insulin or another prescription drug, approved by the United States Food and Drug Administration if the equipment or supplies are determined by a physician or other health care practitioner to be medically necessary and appropriate.

Durable Medical Equipment

means items that: are designed for and able to withstand repeated use by more than one person; customarily serve a therapeutic purpose with respect to a particular Illness or Injury, as certified in writing by the attending medical provider; generally are not useful in the absence of Illness or injury; are appropriate for use in the home; and are of a truly durable nature.. Such equipment includes, but is not limited to, crutches, hospital beds, wheel chairs, respirators, and dialysis machines. Durable Medical Equipment items that are not covered, include but are not limited to those that are listed under “Durable Medical Equipment” in the “Services and Benefits” section of this Plan.

Effective Date

means the date on which coverage under this Plan begins for You and any of Your Dependent(s).

Emergency Medical Condition

means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in

1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2) serious impairment to bodily functions; or
3) serious dysfunction of any bodily organ or part; or
4) serious disfigurement.

Emergency Services

means, with respect to an Emergency Medical Condition:

(a) a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Essential Health Benefits

means, Covered Expenses in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, Mental Health and Substance Use Disorder services, including behavioral health treatment, Prescription Drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Experimental, Investigational and Unproven Services

means a drug, device or medical treatment or procedure is considered Experimental or Investigational if;

- it has not been demonstrated through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or evaluating the condition or Illness for which its is proposed; or
- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows it is the subject of ongoing phase I, II or III clinical trials or understudy to determine if maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the state or means of treatment or diagnosis;
- or reliable evidence shows that the consensus of the opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the stated means of treatment of diagnosis.

Reliable evidence means only; the published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure; or the medical informed consent used by the treating facility or other facilities studying substantially the same Drug, devices or medical treatment or procedure.

Family Deductible

Means the deductible applies if You have a family plan and You and one or more of your Family Member(s) are enrolled under this Plan. Each Member can contribute up to the Individual Deductible amount toward the Family Deductible. The Individual Deductible paid by each Family Member counts towards satisfying the Family Deductible. Once the Family Deductible amount is satisfied, the remaining Individual Deductibles will be waived for the remainder of the Year. The amount of the Family Deductible is described in the Schedule of Benefits for this Plan.

Family

means the group of individuals consisting of a Subscriber and his or her Dependents enrolled for coverage under this Plan. Family Member refers to any one of these individuals.

Family Out-of-Pocket Maximum

applies if You cover other Family Member(s), and means the maximum amount of Deductibles, Percentage Copayments or Copayments You and Your Family Member(s) will be responsible to pay for Covered Services in a Year. Each Member can contribute up to the Individual Out-of-Pocket amount toward the Family Out-of-Pocket maximum. When the Family Out-of-Pocket is met, You and Your Dependent(s) will no longer be responsible to pay Percentage Copayments or Copayments for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year. The amount of the Family Out-of-Pocket Maximum is described in the Schedule of Benefits for this Plan.

Foreign Country Provider

is any institutional or professional provider of medical or psychiatric treatment or care who practices in a country outside the United States of America.

Formulary

Please refer to the definition of Prescription Drug List in this section.

Free-Standing Outpatient Surgical Facility

means an institution which meets all of the following requirements:

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

Generic Prescription Drug (or Generic)

means a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug or Drugs, as the case may be.

Habilitative Services

means services that are:

- designed to assist a child to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame,
- (are expected to result in significant and measurable therapeutic or developmental improvement over a clearly defined period of time, and
- are individualized and there is documentation outlining quantifiable, measurable and attainable treatment goals.

Home Health Agencies and Visiting Nurse Associations means home health care providers that are businesses licensed by the Texas Department of Human Services under Chapter 142, Health and Safety Code to provide skilled nursing and other services on a visiting basis in Your home.

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

Hospice Care Services means any services provided by: (a) a Participating Hospital, (b) a participating skilled nursing facility or a similar institution, (c) a participating home health care agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program, which is a participating Medicare-approved Hospice Care Program.

Hospice Facility means a participating institution or part of it which primarily provides care for Terminally Ill patients; is a Medicare-approved hospice care facility; meets standards established by Cigna; and fulfills all licensing requirements of the state or locality in which it operates.

Hospital means a facility that provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians. It must:

- be licensed as a Hospital and operated pursuant to law; and
- be primarily engaged in providing or operating (either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians) medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
- provide 24 hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
- be an institution which maintains and operates a minimum of 5 beds; and
- have x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
- maintain permanent medical history records.

This definition **excludes** convalescent homes, convalescent facilities, rest facilities, nursing facilities, or homes or facilities primarily for the aged, drug addicts, alcoholics and those primarily affording Custodial Care, educational care or those primarily affording care for mental and nervous disorders.

Hospital Services means, except as limited or excluded by the Plan, services for registered bed patients or outpatients which are customarily provided by acute care Hospitals and which are authorized by Cigna as specified in the “Services and Benefits” Section.

Individual Deductible means the amount of Covered Expenses incurred from Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual Deductible is described in the Schedule of Benefits.

Individual Out-of-Pocket Maximum means the annual limit on Out-of-Pocket expense for each Member covered under this Plan. Once the Individual Out-of-Pocket Maximum has been met for the Year, for Covered Services, You will no longer have to pay any Deductible, Percentage Copayments or Copayments for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year. Non-compliance penalty Charges do not apply to the Individual Out-of-Pocket Maximum and will always be paid by You. The Individual Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred during a Calendar Year. It includes Deductibles, Percentage Copayments and Copayments for Covered Services. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits.

Illness is a sickness, disease, or condition of a Member.

Infertility is the condition of an otherwise presumably healthy individual who is unable to conceive or produce conception during a period of one Year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

Infusion and Injectable Specialty Prescription Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional for rare and/or chronic conditions. These medications include but are not limited to hemophilia factor and supplies, enzyme replacements and Intravenous immunoglobulin. Such specialty medications may require medical and pharmacy Prior Authorization.

Injury Means an accidental bodily injury

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

- The provider's normal charge for a similar service or supply; or
- A 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 an industry standard database.

Medical Services means, except as limited or excluded by the Plan, those professional services of Physicians or Other Participating Health Professionals, including medical, surgical, diagnostic, therapeutic, and preventive services authorized by Cigna as specified in the “Services and Benefits” Section.

Medically Necessary/ Medical Necessity

services or supplies are those that are determined by the Cigna Medical Director to be **all** of the following:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Not primarily for the convenience of any Member, Physician, or another Provider.
- Within generally accepted standards of good medical practice within the community of qualified professionals.
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.
- The most appropriate procedure, supply, equipment or service which can be safely provided and that satisfies the following requirements:
  i) Must have been proven by scientific studies published in peer-reviewed medical literature to be associated with beneficial health outcomes, demonstrating that the expected health benefits are clinically significant and producing a greater likelihood of benefits, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and
  ii) Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
  iii) For hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The fact that a Provider prescribed, ordered, recommended or approved a service, supply, treatment or Confinement does not in and of itself make it Medically Necessary or a Medical Necessity.

Member

means an individual enrolled under this Plan who is entitled to receive services and benefits hereunder, including the Subscriber and his or her Dependent(s).

Mental, Emotional or Functional Nervous Disorders

are neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Mental Health Services

means services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes, including Serious Mental Illness.

Network Specialist means a specialty-practice Physician who is part of the Plan's HMO Participating Provider Network at the time services are rendered.

Non-Participating: Physician / Specialist / Facility / Provider ; Out-of-Network Provider means a Physician, specialist, Facility or other Provider who is not part of the Participating Provider network used by this Plan.

Office Visit means a visit by the Member, who is the patient, to the office of a Physician during which one or more of only the following 3 specific services are provided:

- History (gathering of information on an Illness or Injury)
- Examination
- Medical Decision Making (the Physician's diagnosis and plan of treatment)

This does not include other services (e.g. x-rays or lab services) even if performed on the same day.

Other Participating Health Care Facility means any facility other than a Participating Hospital or Hospice Facility which is operated by or has an agreement with Cigna to render services to Members. Other Participating Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals, and sub-acute facilities.

Other Participating Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver Medical Services and who has an agreement with Cigna to render services to Members. Other Participating Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

Out –of-Pocket Maximum means the maximum amount of Deductible, Copayment and Percentage Copayment each Individual or Family incurs in Covered Expenses from Participating Providers in a Year.

Participating Hospital means an institution that is licensed as an acute care Hospital under applicable state law and that has an agreement with Cigna to provide Hospital Services to Members.

Participating Pharmacy means a retail pharmacy with which Cigna has contracted to provide prescription services to Members; or a designated mail-order pharmacy with which Cigna has contracted to provide mail-order prescription services to Members.

Participating Physician means a Primary Care Physician or other Physician who has an agreement with Cigna to provide Medical Services to Members.

Participating Provider means Participating Hospitals, Participating Physicians, Other Participating Health Professionals, and Other Participating Health Care Facilities.

Pharmacy means a retail Pharmacy or a mail order Pharmacy.

Percentage Copayment means the percentage of Covered Expenses the Member is responsible for paying after applicable Deductibles are satisfied. Percentage Copayment **does not include Copayments. Percentage Copayment** also **does not include charges for services that are not Covered Services or charges in excess of Covered Expenses, or charges which are not Covered Expenses under this Plan.**

Pharmacy & Therapeutics (P&T) Committee means a committee of Cigna Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

Physician means an individual who is qualified to practice medicine under applicable state law or a partnership or professional association of such persons and is a licensed Doctor of Medicine or Doctor of Osteopathy.

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

Pediatric Vision Services means vision care examinations, and other services or treatment described in the "Pediatric Vision Services" section of this Plan provided to a Member who is under age 19.

Plan means the benefits and provisions of this Agreement, as issued by Cigna Healthcare of Texas, Inc..

Physical and/or Occupational Therapy/Medicine means the therapeutic use of physical agents other than Drugs. It comprises the use of physical, chemical and other properties of heat, light, water, electricity, massage, exercise, spinal manipulation and radiation.

Plan Year means the year commencing on January 1 and ending on December 31 unless otherwise defined in Your new Member kit or annual renewal notification

Premium means the sum of money paid periodically to Cigna by You in order for You and your Dependents to receive the services and benefits covered by the Plan.

Prescription Drug means:

- a drug which has been approved by the Food and Drug Administration for safety and efficacy;
- certain drugs approved under the Drug Efficacy Study Implementation review; or
- drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

Prescription Order means a lawful Authorization for a Prescription Drug or Related Supply by a Physician or other Provider who is duly licensed to make such Authorization within the course of such Physician's professional practice or each authorized refill thereof.

Prostheses/Prosthetic Appliances and Devices Prostheses/prosthetic appliances and devices are defined as artificial devices fabricated as replacements for missing parts.

Prostheses/prosthetic appliances and devices include, but are not limited to:

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

Priority Review Means an FDA classification for drugs where significant improvement is expected compared to marketed products, in the treatment, diagnosis, or prevention of a disease.

Primary Care Physician/Provider/ PCP means a Physician engaged in general practice, family practice, internal medicine or pediatrics who, through an agreement with Cigna, provides basic health services to and arranges specialized services for those Members who select him or her as the Physician principally responsible for their medical care.

Prior Authorization means the approval a Participating Provider must receive from the Cigna Medical Director, prior to services being rendered, in order for certain Service and Supplies to be covered under this Plan.

Qualified Medical Child Support Order

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

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

If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such notice meets the requirement above

Reconstructive Surgery means surgery to correct the appearance of abnormal looking features or characteristics of the body caused by birth defects, injury, tumors or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. Reconstructive Surgery includes surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal craniofacial structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease. Reconstructive Surgery also includes "breast reconstruction". For the purpose of this Plan, breast reconstruction means reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.

Referral means the approval You must receive from Your PCP in order for the services of a Participating Provider, other than the PCP, participating Obstetrician/Gynecologist or participating vision care provider to be covered.

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for self-injectables outpatient prescription drugs that are not dispensed in pre-filled syringes, inhalers, inhaler spacers for the management and treatment of pediatric asthma and other conditions, diaphrams, cervical caps, contraceptive rings, contraceptive patches and oral contraceptives (including emergency contraceptive pills); disposable needles and syringes needed for injecting covered drugs and supplements.

Rehabilitative Therapy means, except as excluded by the Plan, treatment modalities which are part of a rehabilitation program, including physical therapy and occupational therapy.

Schedule of Benefits The part of this Plan that identifies applicable Copayments, Percentage Copayments, Deductibles and maximums.

Self-administered Injectable Drugs means Injectable Drugs which are approved for self-administration by the Food and Drug Administration.

Serious Mental Illness means the following psychiatric Illnesses defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

1) Bipolar disorders (hypomanic, manic, depressive, and mixed);
2) Depression in childhood and adolescence;
3) Major depressive disorders (single episode or recurrent);
4) Obsessive−compulsive disorders;
5) Paranoid and other psychotic disorders;
6) Schizo−affective disorders (bipolar or depressive); and
7) Schizophrenia.

Service Area is any place that is within the cities, counties and/or zip code areas in the state of Texas that Cigna has designated as the Service Area for this Plan, as shown in the map at the front of this Evidence of Coverage. For specific information regarding Your Service Area, please check the Provider Directory at www.cigna.com or call the number on the back of your ID card.

Skilled Nursing Facility means an institution that provides continuous skilled nursing services and that:

- is licensed and operated pursuant to state law;
- is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician;
- provide continuous 24-hours-per-day nursing service by or under the supervision of a registered graduate professional nurse (R.N.), and
- maintain a daily medical record on each patient.

This definition excludes any home, facility or part thereof used primarily for rest; a home or facility primarily for the aged or for the care of drug addicts or alcoholics; a home or facility primarily used for the care and treatment of tuberculosis, mental diseases or disorders or custodial or educational care.

Smoking Cessation Attempt Means 4 tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling); and certain Food and Drug Administration (FDA)-approved tobacco cessation medications (including prescription medications and

over-the-counter medications with a Physician's prescription) for a 90-day treatment regimen. Please see your Prescription Drug List for details.

Special Care Units means special areas of a Hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Specialty Medication means medications which are used to treat an underlying disease which is considered to be chronic conditions which include, but are not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Medications may include high cost medications as well as medications that may require special handling and close supervision when being administered.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Subscriber means an individual who meets the eligibility requirements of the "Subscriber" provision of the "Eligibility" Section and enrolls under the Plan. The Subscriber is a party to the Plan.

Substance Use Disorder means the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable,

Substance Use Disorder Residential Treatment Center means an institution which

a. specializes in the treatment of psychological and social disturbances that are the result of substance abuse;

b. provides a sub-acute, structured, psychotherapeutic treatment program, under the supervision of Physicians;

c. provides twenty-four (24) hour care, in which a person lives in an open setting; and

d. is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

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

Telemedicine/Telehealth Telehealth and Telemedicine Medical Services are services provided for the diagnosis, consultation, treatment or transfer of medical data and medical education through the use of Advance Telecommunications Technology, other than by telephone or facsimile. Such Advanced Telecommunications Technology includes:

- compressed digital interactive video, audio or data transmission;

- clinical data transmission using computer imaging by way of still-image capture; and
- other technology that facilitates access to health care services or medical specialty expertise.

Terminal Illness/ Terminally Ill means an Illness of a Member which has been diagnosed by a Physician and for which the Member has a prognosis of six months or less to live.

Urgent Care means health care services provided in a situation other than an emergency which are typically provided in a setting such as a physician or individual provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health.

We/Us/Our means Cigna HealthCare of Texas, Inc.

You, Your, and Yourself means any Member(s) covered under this Plan.

ELIGIBILITY

To be eligible for covered Services and Supplies You must be enrolled as a Member and pay the applicable premium according to the provisions of this Plan.

To be eligible to enroll as a Member You must meet either the Subscriber or Dependent eligibility criteria listed below.

This Plan is for residents of the state of Texas. The Subscriber must notify Us of all changes that may affect any Member's eligibility under this Plan.

Subscriber

To be eligible to enroll as a Subscriber, You must:

- be a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and are reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought;
- be a resident of the state of Texas;
- not be incarcerated other than incarceration pending the disposition of charges;
- live within the Service Area of this Plan; and
- submit a completed and signed application for coverage and have been accepted in writing by Us.

Dependent

To be eligible to enroll as a Dependent, You must:

- Be the Subscriber's lawful spouse and reside in the Service Area; or
    - Be a child of the subscriber by birth, adoption, or foster care who lives in the Service Area and has not yet reached age 26; or
    - Be a stepchild of the Subscriber who lives in the Service Area and has not yet reached age 26; or.
    - Be a grandchild of the Subscriber who lives in the Service Area and has not yet reached age 26 if You are the Subscriber's dependent for Federal Income Tax purposes at the time of application; or
    - Be the Subscriber's or the Subscriber's spouse's unmarried children, regardless of age, enrolled prior to age 26, who live in the Service Area and are incapable of self-support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Subscriber for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
    - The Subscriber's or the Subscriber's Spouse's Newborn children are automatically covered for the first 31 days of life. To continue coverage past that time, You must enroll the child as a dependent Member by applying for his or her enrollment as a dependent within 61 days of the date of birth, and pay any additional premium. Coverage for a newborn dependent child enrolled within 61 days of birth will be retroactive to the date of the child's birth.

- An adopted child, including a child who is placed with You for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage past that time, You must enroll the child as a dependent Member by applying for his or her enrollment as a dependent within 61 days of the date of adoption, and pay any additional premium. Coverage for an adopted dependent child enrolled within 61 days of adoption will be retroactive to the date of the child's placement for adoption or initiation of a suit of adoption.
- If a court has ordered a Subscriber to provide coverage for an eligible child (as defined above), coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage past that time, You must enroll the child as a dependent Member by applying for his or her enrollment as a dependent within 61 days of the court order date, and paying any additional premium. Court-ordered coverage for a dependent child enrolled within 61 days of the court order will be retroactive to the date of the court order.

A child who is the subject of a qualified medical child support order, who resides outside of the Service Area but inside the United States, is entitled to receive while outside the Service Area comparable coverage, **not** limited to out-of-area emergency benefits under the "Emergency Services" provision of the "Services and Benefits" section.

When Can I Apply?

Application to Enroll or Change Coverage

The Patient Protection and Affordable Care Act of 2010 (PPACA) specifies that an eligible person must enroll for coverage or change plans during the Annual Open Enrollment Period. Persons who fail to enroll or change plans during the Open Enrollment Period must wait until the next Open Enrollment Period to enroll in a plan or to change plans. However, if a person experiences a triggering event as described below, the triggering event starts a 60-day Special Enrollment Period during which an eligible person can enroll and a Subscriber can add dependents and change coverage.

The Annual Open Enrollment Period and Special Enrollment Period are explained below.

Annual Open Enrollment Period

The Annual Open Enrollment Period is a specified period of time each Year during which individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another.

To be enrolled for coverage under this Plan, You must submit a completed and signed application for coverage under this Plan for Yourself and any eligible Dependent(s), and We must receive that application during the Annual Open Enrollment Period.

Your coverage under this Plan will then become effective pon the earliest day allowable under federal rules for that Year's open enrollment period. **Note: If You do not apply to obtain or change coverage during the Annual Open Enrollment Period, You will not be able to apply again until the following Year's Annual Open Enrollment Period** unless You qualify for a special enrollment period as described below.

Special Enrollment Periods

A special enrollment period occurs when a person experiences a triggering event.

If You experience one of the triggering events listed below, You can enroll for coverage and enroll Your eligible Dependent(s) during a special enrollment period instead of waiting for the next Annual Open Enrollment Period.

Triggering events for a special enrollment period are:

- An eligible individual, and any dependent(s), loses his or her minimum essential coverage;
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours;
- An eligible individual gaining or becoming a dependent through marriage, birth adoption or placement for adoption;
- An eligible dependent spouse or child losing coverage under an employer-sponsored health plan due to the employee's becoming to Medicare, divorce or legal separation of the covered employee, and death of the covered employee; or
- An eligible individual losing his or her dependent child status under a parent's employer-sponsored health plan;
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or (This is only applicable to the marketplace)
- An eligible individual being enrolled or non-enrolled in a qualified health plan unintentional, inadvertent or erroneous, and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the marketplace. In such cases, the marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrating to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gaining access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- A Native American, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month; (This is only applicable to coverage on the Marketplace)
- An eligible individual or enrollee demonstrates to the relevant marketplace, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the marketplace may provide.

Triggering events **do not** include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will have coverage effective dates determined as follows:

- in the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care;
- in the case of marriage, or in the case where a qualified individual loses minimum essential coverage, coverage is effective for a qualified individual or enrollee on the first day of the following month.

For all other triggering events the effective dates are:

- for an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- for an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

Except as described in the Continuation section, a Member **will become ineligible for coverage** under the Plan upon the earliest of the following (as applicable):

- if Cigna determines that any Member covered under this Plan has engaged in fraud or intentional misrepresentation of facts with respect to the Member's application for, coverage under, or receipt of benefits pursuant to this Agreement, subject to the "Incontestability" provision of this EOC, Cigna may cancel coverage after not less than 15 days' written notice;
- when premiums are not paid according to the due dates and grace periods described in the Plan, Cigna may cancel coverage without written notice when the grace period has expired;
- for a spouse, when the spouse is no longer married to the Subscriber;
- for You and Your family Member(s) when You no longer meet the requirements listed in the Eligibility section;
- the date Cigna ceases to offer this Plan in the market, or when Cigna ceases to offer this type of Plan in the market, but only if coverage is discontinued uniformly without regard to health status-related factors of Members who may become eligible for coverage, Cigna may cancel coverage after 90 days' written notice. In that event, Cigna must offer to each Member on a guaranteed-issue basis any other individual basic health care coverage offered by Cigna in that Service Area; or
- the date Cigna ceases to offer all health plans in the individual market within the Service Area, but only if coverage is discontinued uniformly without regard to health status-related factors of Members who may become eligible for coverage. Cigna may cancel coverage after 180 days' written notice to the commissioner and the Members, in which case the Cigna may not re-enter the individual market in that Service Area for five years beginning on the date of discontinuance at the last coverage not renewed.
- when the Subscriber no longer resides, lives or works in the Service Area. So long as coverage is terminated uniformly without regard to any health status-related factor of enrollees, coverage may be canceled after 30 days' written notice. However, Cigna may not cancel the coverage for a child who

is the subject of a medical support order because the child does not reside, live, or work in the service area.

It is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Dependents(s) eligibility for benefits under this Plan.

Continuation

If an Member's eligibility under this Plan would terminate due to the Subscriber's death, divorce or if other Member(s) would become ineligible due to age or no longer qualify as Dependents for coverage under this Plan; except for the Subscriber's failure to pay premium, that Member has the right to continuation of his or her insurance. Coverage will be continued if the Member exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Plan would otherwise terminate. In such a case, coverage will continue without evidence of insurability.

EFFECTIVE DATE OF COVERAGE

Subject to the provisions of this Plan, including payment of applicable Premiums in accordance with the "Payments" Section of this Plan, Your coverage will become effective at 12:01 a.m. on the first day of the month following compliance with the eligibility and enrollment requirements of, and acceptance by, Cigna. Your Dependent shall have the same effective date as You, unless his or her dependent status is established after such date.

Confined to a Hospital

If You are confined in a Hospital on the effective date of Your coverage, You must notify us of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter. When You become a Cigna Member, You agree to permit Cigna to assume direct coordination of Your health care. We reserve the right to transfer You to the care of a Participating Provider and/or Participating Hospital if the Cigna Medical Director, in consultation with Your attending Physician, determines that it is medically safe to do so.

If You are hospitalized on the effective date of coverage and You fail to notify us of this hospitalization, refuse to permit us to coordinate Your care, or refuse to be transferred to the care of a Participating Provider or Participating Hospital, we will not be obligated to pay for any medical or Hospital expenses that are related to Your hospitalization following the first two (2) days after Your coverage begins.

PAYMENTS

Premiums and Grace Period for Members who purchased this HMO Plan Off-Marketplace

If You did not purchase Your Plan from a state based, partnership or federal facilitated marketplace, or elect to not receive advanced premium tax credit, there is a grace period of 31 days for the receipt at Our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period, however, if We do not receive your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums.

Premiums and Grace Period for Members who purchased this HMO Plan On-Marketplace

If You purchased Your Plan from a state based, partnership or federal facilitated marketplace and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period, Your coverage will be terminated as of the last day of the first month of the grace period.

Member Payments

You are required to pay all Copayments and Member Percentage Copayments for services rendered. Copayments and Percentage Copayments are subject to change upon Plan renewal once per Year. You are liable for all Copayments and Percentage Copayments incurred by Yourself and any of Your Dependents. See Your Schedule of Benefits for further detail.

Cigna will not accept the direct or indirect payment of premiums by any person or entity other than You, Your Family Members or an Acceptable Third Party Payor.

Premium Payments ONLY by Subscriber or Acceptable Third Party Payor

Cigna will not accept the direct or indirect payment of premiums by any person or entity other than You, Your Family Members or an Acceptable Third Party Payor.

Premium

Your premium may change from time to time due to (but not limited to):

- Deletion or addition of a new eligible Member(s)
- A change in age of any member which results in a higher premium
- A change in residence

These changes will be effective on the first of the month following the change, unless as otherwise stated on Your premium notice.

Cigna also reserves the right to change the premium on 60 days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Members in the same class and covered under the same Plan as You. The change will become effective on the date shown on the notice, and payment of the new premiums will indicate acceptance of the change.

SERVICES AND BENEFITS

Members are entitled to receive the services and benefits set forth in this Section, subject to payment of Copayments, Percentage Copayments and any applicable Deductible as specified in the Schedule of Benefits, and subject to the conditions, limitations and exclusions of this Plan. UNLESS PRIOR WRITTEN APPROVAL OF THE CIGNA MEDICAL DIRECTOR IS RECEIVED, SERVICES AND BENEFITS SET FORTH BELOW ARE AVAILABLE ONLY IF MEDICALLY NECESSARY, RENDERED BY PARTICIPATING PROVIDERS, AND EITHER PROVIDED OR AUTHORIZED IN WRITING BY THE MEMBER'S PRIMARY CARE PHYSICIAN.

Services that require Prior Authorization include, but are not limited to, inpatient Hospital services, inpatient services at any Other Participating Healthcare Facility, outpatient facility services, advanced radiological imaging, non-emergency ambulance, and transplant services. Prior authorization for non-emergency ambulance services may be obtained from a Participating Provider that is treating the Member.

Prior Authorization requirements for Prescription Drugs are detailed in the "Prescription Drugs" section of this Plan.

PRIOR WRITTEN AUTHORIZATION IS NOT REQUIRED FOR "EMERGENCY SERVICES", AND "OBSTETRICAL AND GYNECOLOGICAL SERVICES", **"**PEDIATRIC VISION" AND "PEDIATRIC DENTAL" SERVICES.

AS SET FORTH IN THIS SECTION. SERVICES FROM NON-PARTICIPATING PROVIDERS ARE NOT AVAILABLE EXCEPT AS DESCRIBED IN THE "EMERGENCY SERVICES" PROVISION OF THE "SERVICES AND BENEFITS" SECTION OR WITH THE PRIOR APPROVAL OF THE CIGNA MEDICAL DIRECTOR.

Physician Services

Coverage is provided for all diagnostic and treatment services provided by Participating Physicians and Other Participating Health Professionals, including office visits; periodic health assessments; preventive care, including well-child care and routine immunizations provided in accordance with accepted medical practices; hospital care; consultation; and surgical procedures.

Outpatient Services

Coverage is provided for services provided on an outpatient basis, including: diagnostic and/or treatment services; administered drugs, medications, fluids, biologicals, blood and blood products; inhalation therapy; radiation therapy, chemotherapy and hemodialysis treatment, and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, and recovery room services.

Inpatient Hospital Services

Coverage is provided for inpatient Hospital services for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in an Other Participating Health Care Facility. Inpatient Hospital services include semi-private room and board; care and services in an intensive care unit; drugs, medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets when Medically Necessary; dressings and casts; general nursing care; special duty nursing when Medically Necessary; use of operating room and related facilities; laboratory and radiology services and other

diagnostic and therapeutic services; anesthesia and associated services; inhalation therapy; radiation therapy; administration of blood and blood plasma; short-term rehabilitation therapy services in the acute hospital setting; admit kit, and other services which are customarily provided in acute care hospitals. Inpatient Hospital services also include Birthing Center.

Inpatient Services at Other Participating Health Care Facilities

Coverage is provided for inpatient services at Other Participating Health Care Facilities, up to any applicable day maximum shown in the Schedule of Benefits, when Medically Necessary as determined by the Cigna Medical Director. Coverage is provided for inpatient services at Other Participating Health Care Facilities including semi-private room and board; skilled and general nursing services; Physician visits; physiotherapy; speech therapy; occupational therapy; x-rays; and administration of drugs, medications, biologicals and fluids. In making determinations as to the medical appropriateness, level or nature of treatment to be provided by a licensed skilled nursing facility, Cigna shall, to the extent reasonably possible, follow the current, as of the date of services, Medicare guidelines on skilled nursing care.

Emergency Services and Urgent Care

Emergency Services Both In and Out of the Service Area. In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or Your local emergency service, police or fire department for help. You do not need a Referral for Emergency Services, but You do need to call Your Primary Care Physician or the CIGNA HealthCare 24-Hour Health Information Line [SM] as soon as possible for further assistance and advice on follow-up care. If You require specialty care or a hospital admission, Your Primary Care Physician or the Cigna HealthCare 24-Hour Health Information Line [SM] will coordinate such care or admission and handle the necessary authorizations for care or admission. Participating Providers are on call twenty-four (24) hours per day, seven (7) days per week, to assist you when You need Emergency Services.

If You receive Emergency Services outside the Service Area, You or the Emergency Services Provider must notify Us as soon as reasonably possible. Any post-stabilization services rendered to You following the Emergency Treatment must be Authorized by Your PCP or Cigna within a reasonable amount of time, but not more than 1 hour from the time of request for authorization of post-stabilization services. We may arrange to have You transferred to a Participating Provider for continuing or follow-up care if it is determined to be medically safe to do so.

Urgent Care Inside the Service Area. For Urgent Care inside the Service Area, you must take all reasonable steps to contact the Cigna HealthCare 24-Hour Health Information Line [SM] or your Primary Care Physician for direction and you must receive care from a Participating Provider, unless otherwise authorized by your PCP or Cigna.

Urgent Care Outside the Service Area. In the event you need Urgent Care while outside the Service Area, you should, whenever possible, contact the Cigna HealthCare 24 Hour Health Information Line [SM] or your Primary Care Physician for direction and authorization prior to receiving services.

Continuing or Follow-up Treatment. Continuing or follow-up treatment, whether in or out of the Service Area, is not covered unless it is provided or arranged for by your Primary Care Physician, a Participating Physician or upon Prior Authorization of the Cigna Medical Director.

Notification, Proof of a Claim, and Payment. Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and authorization by the Cigna Medical Director. Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than within forty-eight (48) hours of admission. This requirement shall not cause denial of an otherwise valid claim if you could

not reasonably comply, provided that notification is given to us as soon as reasonably possible. If you receive Emergency Services or Urgent Care from non-Participating Providers, you must submit a claim to us no later than sixty (60) days after the first service is provided. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided you submit the claim and the itemized statement to us as soon as reasonably possible. Coverage for Emergency Services and Urgent Care received through non-Participating Providers shall be limited to covered services to which you would have been entitled under this Plan, and you will be reimbursed for only the costs that you incur that you would not have incurred if you received the services in-network.

(REMAINDER OF SERVICES ARE LISTED IN ALPHABETICAL ORDER)

Acquired Brain Injury

Medical services for Acquired Brain Injury are covered on the same basis as any other medical condition. This Plan provides benefits for Covered Expenses for Medically necessary services for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services or community reintegration services (including outpatient day treatment services or other post-acute care treatment services) will be covered to treat an acquired brain injury. Reasonable costs for periodic re-evaluations of treatment will be covered. Services in facilities other than hospitals will be covered. The treatment goals for such services do not need to be restorative; they may include the maintenance of functioning or the prevention of or slowing of further deterioration.

With respect to this benefit, the following definitions apply:

For the purposes of this benefit, acquired brain injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Cognitive communication therapy--Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive rehabilitation therapy--Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Community reintegration services--Services that facilitate the continuum of care as an affected individual transitions into the community.

Enrollee--A person covered by a health benefit plan.

Health benefit plan--As described in the Insurance Code § 1352.001 and § 1352.002.

Issuer--Those entities identified in the Insurance Code § 1352.001.

Neurobehavioral testing--An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

Neurobehavioral treatment--Interventions that focus on behavior and the variables that control behavior.

Neurocognitive rehabilitation--Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive therapy--Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback therapy--Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological testing--An evaluation of the functions of the nervous system.

Neurophysiological treatment--Interventions that focus on the functions of the nervous system.

Neuropsychological testing--The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological treatment--Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Other similar coverage--The medical/surgical benefits provided under a health benefit plan. This term recognizes a distinction between medical/surgical benefits, which encompass benefits for physical Illnesses or injuries, as opposed to benefits for mental/behavioral health under a health benefit plan.

Outpatient day treatment services--Structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

Post-acute care treatment services--Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-acute transition services--Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Psychophysiological testing--An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological treatment--Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Remediation--The process(es) of restoring or improving a specific function.

Services--The work of testing, treatment, and providing therapies to an individual with an acquired brain injury.

Therapy--The scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

Ambulance Service

Coverage is provided for emergency transport ambulance services to the nearest provider or facility capable of treating Your Illness or Emergency Medical Condition. Non-emergency transport requires Prior authorization from a Participating Provider that is treating the Member.

Autism Spectrum Disorders

Coverage is provided for diagnosis and treatment of Autism Spectrum Disorders.

For a Member diagnosed with an Autism Spectrum Disorder, treatment for Autism Spectrum Disorders includes the following care prescribed, provided, or ordered by

1) a Physician licensed to practice medicine in all its branches or
2) a certified, registered, or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be medically necessary and ordered by a Physician licensed to practice medicine in all its branches:
   a) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
   b) Psychological care, meaning direct or consultative services provided by a licensed psychologist.
   c) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.

      Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:

a) self-care and feeding,
b) pragmatic, receptive, and expressive language,
c) cognitive functioning,
d) applied behavior analysis, intervention, and modification,
e) motor planning, and
f) sensory processing.

Upon request from Cigna, a provider of treatment for Autism Spectrum Disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is Medically Necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, Cigna may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

Benefits Provided by the Texas Department of Human Services

All benefits payable under this Plan on behalf of a dependent child enrolled under this Plan for which benefits for financial and medical assistance are being provided by the Texas Department of Human Services shall be paid to said department whenever; The Texas Department of Human Services is paying benefits under the Human Resources Code, Chapter 31 or Chapter 32, i.e., financial and medical assistance service programs administered pursuant to the Human Resources Code; and the parent who purchased the individual Plan has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay support.

Cardiac Rehabilitation Services

This Plan provides benefits for Covered Expenses incurred for:

- Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge.
- The Phase II program must be Physician directed with active treatment and EKG monitoring.

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

Cardio Vascular Disease Screening

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

This Plan covers cardiovascular disease screenings made for or in connection with one of the following non-invasive screening tests for atherosclerosis and abnormal artery structure and function. Coverage will be provided for computed tomography (CT) scanning measuring artery calcification; or ultrasonography measuring carotid intima-media thickness and plaque. Such coverage will be provided every five years for a Member who are diabetic or have a high risk of developing coronary heart disease based on a score derived using the Framingham Heart Study prediction algorithm that is intermediate or higher.

Clinical Trials

Benefits are payable for routine patient services associated with an approved clinical trial (Phases I-IV) for treatment of cancer or other life-threatening diseases or conditions for a covered person who meets the following requirements:

1. Is eligible to participate in an approved clinical trial according to the trial protocol with respect to the prevention, detection or treatment of cancer or other life-threatening disease or condition; and
2. Either
   - the referring health care professional is a participating health care provider and has concluded that the individual’s participation in such a trial would be appropriate based upon the individual meeting the conditions described in Paragraph (1); or
   - the covered person provides medical and scientific information establishing that his participation in such a trial would be appropriate based on the individual meeting the conditions described in Paragraph (1).

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

An approved clinical trial must meet one of the following requirements:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be approved for cancer clinical trials by an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services;

- be conducted under an investigational new drug application reviewed by the Food and Drug administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine Patient Services are costs associated with the provision of health care items and services including drugs, items, devices and services typically covered by Cigna for a covered patient who is not enrolled in a clinical trial, including the following:

- services typically provided absent a clinical trial;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine Patient Services do not include:

- the investigational item, device, or service itself;
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Clinical Trials-Life Threatening Diseases

This Plan provides benefits for Covered Expenses made for routine patient care costs in connection with a phase I, II, III or IV clinical trial if the clinical trial is conducted in relation to the prevention, detection or treatment of cancer or other life threatening disease or condition. The clinical trial must be approved by one of the following agencies:

- the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
- the National Institutes of Health;
- the U.S. Food and Drug Administration;
- the U.S. Department of Defense;
- the U.S. Department of Veterans Affairs; or
- an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.
- The Agency for Health Care Research and Quality;
- The Centers for Medicare and Medicaid Services;
- The Department of Energy
- A qualified “non-governmental” research entity identified in the guidelines issued by the National Institutes of Health for center support grants as required under 42 U.S.C. § 300gg-8(d)(1)(A)(vi); or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application under 42 U.S.C. § 300gg-8(d)(1)(C).

Cosmetic Surgery

Cosmetic Surgery is covered only for reconstructive surgery that constitutes Medically Necessary care and treatment of medically diagnosed services required for the prompt repair of accidental injury. Treatment of congenital defects and birth abnormalities is covered for eligible Dependent children.

Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

Non-life threatening complications of a non-covered cosmetic surgery are not covered. This includes, but is not limited to, subsequent surgery for reversal, revision or repair related to the procedure.

Craniofacial Abnormalities

Medical services for Reconstructive Surgery for Craniofacial Abnormalities are paid on the same basis as any other medical condition. Medically Necessary services to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Dental Confinement/Anesthesia

Coverage is provided for facility and anesthesia services for hospitalization in connection with dental or oral surgery if the confinement has been Pre-Certified because of a hazardous medical condition. Such conditions include heart problems, diabetes, hemophilia, dental extractions due to cancer-related conditions, and the probability of allergic reaction (or any other condition that could increase the danger of anesthesia). All facility services must be provided by a Participating Provider.

Diabetes Services

Medical services for Diabetes are covered on the same basis as any other medical condition for a member who meets one of the following criteria:

- A Member who has been diagnosed with insulin-dependent or non-insulin dependent diabetes; or
- A Member who has elevated blood glucose levels induced by pregnancy; or
- A Member diagnosed with another medical condition associated with elevated blood glucose levels.

This Plan provides benefits for Covered Expenses including Diabetes Self-Management Training and education, Diabetes Equipment and Diabetes Pharmaceuticals & Supplies for the treatment of Type I Diabetes, Type 2 Diabetes, and Gestational Diabetes Mellitus as indicated in the Definitions section of this Plan.

Durable Medical Equipment

Cigna Medical Director Charges

Coverage is provided for the purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Participating Physician and provided by a vendor approved by Cigna for use outside a Participating Hospital or Other Participating Health Care Facility. Coverage is provided for repair, replacement or duplicate equipment only when approved as Medically Necessary by the Cigna Medical Director. The determination to either purchase or rent equipment expected to cost $1,000 or more will be made by the Cigna Medical Director. All maintenance and repairs that result from a Member's misuse are

the Member's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the Cigna Medical Director.

Unless covered in connection with the services described in the "Inpatient Services at Other Participating Health Care Facilities" or "Home Health Services" provisions, the following are specifically excluded:

1) Hygienic or self-help items or equipment;
2) Items or equipment primarily used for comfort or convenience such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;
3) Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
4) Institutional equipment, such as air fluidized beds and diathermy machines;
5) Elastic stockings and wigs;
6) Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, braces and splints;
7) Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
8) Items which under normal use would constitute a fixture to real property, such as lifts, ramps, railings, and grab bars; and
9) Hearing aid batteries (except those for cochlear implants) and chargers.

Early Intervention Services for Treatment of Developmental Delays for Children

Payment for Medically Necessary early intervention services for treatment of diagnosed developmental delays will be provided to a child in accordance with the child's individualized family service plan issued by the Interagency Council on Early Childhood Intervention, for rehabilitative and habilitative therapies prescribed by a Physician including:

- Occupational Therapy evaluations and services;
- Physical Therapy evaluations and services;
- Speech therapy evaluations and services;
- Dietary or nutritional evaluations;

Early intervention services means Medically Necessary speech and language therapy, occupational therapy, physical therapy, and dietary or nutritional evaluations for dependents from birth.

External Prosthetic Appliances and Devices

This Plan provides benefits for Covered Expenses made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the Cigna Medical Director in consultation with the Member's Physician. This includes coverage for repair, maintenance or replacement of a covered prosthetic appliance or device, unless replacement is required because of misuse or loss of the prosthetic on the part of the Member.

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

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

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

Orthoses and Orthotic Devices
Orthoses and orthotic devices are defined as customer fitted or custom fabricated medical devices that are applied to a part of the human body to correct a deformity, improve function or relieve symptoms of a disease. Coverage is provided for custom foot orthoses and other orthoses as follows:

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

The following are specifically excluded orthoses and orthotic devices:

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

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

The following braces are specifically excluded: Copes scoliosis braces.

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

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

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

The following are specifically **excluded** external prosthetic appliances and devices:

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

Family Planning Service

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

Foot Disorders – Routine Services

Coverage is provided for routine foot care for the diagnosis and treatment of: corns, calluses, weak or flat feet; any fallen arches, chronic foot strain or instability imbalance of the feet; or toenails (other than removal of nail matrix or root,) in the absence of metabolic or peripheral vascular disease or of a neurological condition.

Foreign Country Providers Services

This Plan provides benefits for Covered Expenses for services and supplies received from Foreign Country Providers only for Medical Emergencies and other urgent situations where treatment could not have been reasonably delayed until the Member was able to return to the United States.

Benefits are subject to all terms, conditions, limitations, penalties, and exclusions of this Plan and will not be more than would be paid if the service or supply had been received in the United States.

Habilitative Services

Coverage is provided for services designed to assist You to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame are payable as stated in the Benefit Schedule.

Coverage is provided for Covered Expenses for the necessary care and treatment of loss or impairment of speech, as stated in the Benefit Schedule.

The term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided. All supplies and additional fees charged in conjunction with these services will be included in the payment of benefits for the visit and will not be reimbursed in addition to the visit.

Home Health Services

Home health services are provided only if the Cigna Medical Director has determined in advance that the home is a medically appropriate setting and has authorized the Home Health Services.

Home health services are those skilled health care services that can be provided during visits by Other Participating Health Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Participating Health Professionals. Necessary consumable medical supplies and home infusion therapy, administered or used by Other Participating Health Professionals in providing home health services are covered.

Home Health Care will be covered only during times when there is a Family Member or caregiver present to meet the Member's non-skilled care and/or custodial service needs. Home health services do not include services by a person who is a member of Your family or Your dependent's family or who normally resides in Your house or Your dependent's house, even if that person is an Other Participating Health Professional. Skilled nursing services or private duty nursing services are not covered outside the home and are subject to the rules that apply to home health services.

Hospice Services

Coverage is provided for Hospice Care Services which are provided under an approved Hospice Care Program when provided to a Member who has been diagnosed by a Participating Physician as having a Terminal Illness with a prognosis of six months or less to live. Hospice Care Services include inpatient care, outpatient services, professional services of a Physician, services of a psychologist, social worker or family counselor for individual and family counseling, and home health services.

Hospice care services do not include the following:

1. services of a person who is a Member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
2. services for curative or life-prolonging procedures;
3. services for which any other benefits are payable under the Plan;
4. services or supplies that are primarily to aid you or your Dependent in daily living;
5. services for respite (Custodial) care;
6. nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

Laboratory, Diagnostic, Therapeutic Radiology and Advanced Imaging Services

Coverage is provided for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.

Mastectomy, Breast Reconstruction and Breast Prostheses

This Plan provides benefits for Covered Expenses for hospital and professional services, for mastectomy and lymph node dissection for the treatment of breast cancer and for the treatment of physical complications of all stages of mastectomy, including lymphedemas, whether or not the mastectomy occurred while the Member was covered under this Plan. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer.

Coverage is provided for the following Services and Supplies following a mastectomy:

1. surgical services for reconstruction of the breast on which the mastectomy was performed;
2. surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
3. post-operative breast prostheses; and
4. mastectomy bras/camisoles and external prosthetics that meet external prosthetic placement needs.

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

Maternity Care Services

Coverage is provided for Medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, cesarean section, spontaneous abortion (miscarriage) and complications of pregnancy, and maternal risk.

Coverage for a mother and her newly born child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. In the case of a shorter inpatient stay, one follow-up visit will be provided in the mother's home; the provider's office; a health care facility or some other appropriate location.

This Plan provides benefits for Complications of Pregnancy. Benefits are available for other pregnancy and maternity care as indicated above under "Maternity Care Services".

We will not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization for prescribing a length of stay that does not exceed the above periods. However, We may provide benefits for a shorter stay if the attending provider (e.g.,the Physician, nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

Medical Supplies

Coverage is provided for Medically Necessary medical supplies that are required for a Member in a course of treatment for a specific medical condition. Supplies must be obtained from a Participating Provider. Over the counter supplies, such as band-aids and gauze, are not covered. If a medical supply is specifically excluded from coverage by another provision of this Plan, this paragraph will not be construed to provide coverage for that supply.

Mental Health, Serious Mental Illness and Substance Use Disorder Services

In order to qualify for benefits, services for Mental, Emotional or Functional Nervous Disorders, Serious Mental Illness and or Substance Use Disorder must meet the following conditions:

- Services must be for the treatment of a Mental, Emotional or Functional Nervous Disorder, Serious Mental Illness and Substance Use Disorder that can be improved by standard medical practice.
- The Member must be under the direct care and treatment of a Physician for the condition being treated.
- Services must be those which are regularly provided and billed by a Hospital or a Physician.

- Services are covered only for the number of days or visits which are Medically Necessary to treat the Member's condition.
- Inpatient Services must be received in a Hospital or Day Care Center for inpatient treatment.

Newborn/Infant Hearing Screening

Payment will be provided for the following hearing services for a newborn or infant Member as outlined below:

1. A screening test for hearing loss; and
2. Necessary diagnostic follow-up care related to screening tests.

The Member is not responsible for any additional payment for Covered Expense for Participating Providers. The Member will not be subject to any deductibles for these services.

Nutritional Formulas: Amino Acid-Based Elemental Formula

This Plan provides benefits for Covered Expenses made for amino acid-based elemental formulas and the services associated with administration of the formulas when prescribed by the treating physician, regardless of the formula delivery method, that are used for the diagnosis and treatment of:

- immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- severe food protein-induced enterocolitis syndrome;
- eosinophilic disorders, as evidenced by the results of a biopsy; and
- impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Amino acid based elemental formulas may be reviewed for Medical Necessity.

Obstetrical and Gynecological Services

Coverage is provided for obstetrical and gynecological services that are provided by qualified Participating Providers for pregnancy, well-women gynecological exams, primary and preventive gynecological care and acute gynecological conditions. For these Services and Supplies you have direct access to qualified Participating Providers; you do not need a Referral from your PCP.

Preventive Care -Periodic Health Examinations

Immunizations

Covered immunizations for adults and children from birth include:

1. Influenza, Trivalent inactivated influenza vaccine (TIV);
2. Influenza, Live attenuated influenza vaccine (LAIV);
3. Haemophilus influenzae type b
4. Pneumococcal;
5. Hepatitis B (Hep B);
6. Hepatitis A (Hep A);
7. Td (Tetanus, diphtheria);
8. Polio (IPV);

9. Varicella (Var);
10. Meningococcal Conjugate vaccine (MCV4);
11. MMR (Measles, mumps, rubella);
12. Pertussis
13. rotavirus
14. HPV Vaccine;
15. Shingles Vaccine.

Preventive Care Services

Coverage is provided for Preventive Care Services including the following:

1. routine physical exams;
2. charges made in connection with mammograms, and annual pap test, osteoporosis screening and routine maternity screening;
3. charges made in connection with colorectal cancer screening;
4. charges for annual prostate specific antigen (PSA) screening and digital rectal examination (DRE);
5. charges for well child visits and immunizations as are recommended by the American Academy of Pediatrics;
6. charges for an annual well woman exam;
7. charges for an annual well man exam;
8. routine vision and hearing screenings performed by a PCP;
9. items or services that have an A or B rating in current recommendations of the U. S. Preventive Services Task Force (USPSTF);
10. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
11. for infants from birth, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
12. for women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, such as breastfeeding equipment, supplies, and counseling; and screening for gestational diabetes, HPV testing, counseling for STD infections, counseling and screening for HIV, and interpersonal and domestic violence.
13. Prescription drugs, over-the-counter drugs and vitamins required by the Patient Protection and Affordable Care Act (PPACA) are covered under the Prescription Drug benefits of this Plan; these include, but are not limited to: prescription and over-the-counter contraceptives, tobacco cessation products and prenatal vitamins. Please see the Prescription Drug Benefits section for more information.

Cervical and Ovarian Cancer and Human Papillomavirus Testing

This Plan provides benefits for Covered Expenses made for an annual medically recognized diagnostic examination for the early detection of cervical or ovarian cancer for each covered female. Such coverage shall include at a minimum: (a) a conventional Pap smear screening; or (b) a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, and a CA125

blood test for the early detection of ovarian cancer, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Services for Short Term Rehabilitative Therapy (Physical and Occupational Therapy)

Coverage is provided for the therapeutic use of heat, cold, exercise, electricity, ultraviolet light, or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury; and the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

All Covered Supplies and additional fees properly charged in conjunction with these services will be included in the payment of benefits for the visit and will not be reimbursed in addition to the visit.

The term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided.

Coverage is limited to therapy services that are restorative in nature. Restorative therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of injury or sickness. Restorative therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the injury or Illness. Services are not covered when they are considered by the Cigna Medical Director to be custodial, training, educational or developmental in nature. Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living after an Illness or injury. Note: this provision does not apply to services for Habilitative Therapy.

The following services are specifically excluded from coverage under the Short Term Rehabilitative Services benefit:

1. Services of a Provider that are not within his or her scope of practice, as defined by state law;
2. Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent reoccurrence or to maintain the patient's current status;
3. Vitamin therapy; and
4. Massage therapy in the absence of other modalities.

Smoking Cessation

This Plan provides benefits for Covered Expenses for two Smoking Cessation Attempts, as defined in the Plan, per Year per Member.

Speech and Hearing

Payment will be provided for the following hearing services for a Member as outlined below:

1. Services of a Physician to restore or correct an impaired speech or hearing function;
2. Hearing aids, subject to any limit shown in the Plan Benefit Schedule.

Telehealth/Telemedicine Medical Services

Medical Services for Telehealth/Telemedicine are covered on the same basis as any other medical benefit. Please refer to the "Definitions" section of this Plan for a complete description of the services.

Treatment for Temporomandibular Joint Disorder/Dysfunction (TMJ)/Orthognathic Surgery

This Plan provides benefits for Covered Expenses for charges for diagnostic and surgical treatment for conditions effecting temporomandibular joint and craniomandibular disorders which are a result of:

(a) an accident;

(b) trauma;

(c) a congenital defect;

(d) a developmental defect; or

(e) a pathology.

Dental services (i.e. dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums), or orthodontic services (i.e. braces and other orthodontic appliances) are not covered by this Plan for any diagnosis, including TMJ.

Transplant Services

This Plan provides benefits for Hospital and professional services as described for:

- A Member who receives the organ or tissue.

Benefits for the donor are payable only after benefits have been paid for the Member's expenses, and then only to the extent benefits are available under the recipient's Plan.

Cigna has established a network of transplant facilities known as **Cigna LIFESOURCE Transplant Network® Facilities (Lifesource Facilities)** to provide services for specified organ and tissue transplants, including:

- heart
- liver
- lung
- heart/lung
- kidney
- simultaneous pancreas/kidney
- pancreas
- pancreas or intestine which includes small bowel-liver or multi-visceral
- bone marrow/stem cell harvest and transplant, including autologous and allogenic bone marrow/stem cell transplant

Note: A Participating Provider is not necessarily a Cigna LIFESOURCE Transplant Network® Facility.

Cornea transplants are **not** available at Cigna LIFESOURCE Transplant Network® Facilities. All other transplant services are covered when received at Cigna LIFESOURCE Transplant Network® Facilities. Transplant services, including cornea, received from non-LIFESOURCE Participating Provider facilities that are specifically contracted for those services are payable at the In-Network level.

The following Organ and Tissue Transplants charges are excluded from payment under the Plan:

- Charges incurred prior to pre-transplant evaluation.
- Charges incurred for testing administered to people other than the living donor.
- Charges for any treatment, supply or device which is found by Cigna to be Experimental, Investigative or not a generally accepted medical practice.
- Charges for transplant of animal organs to a human recipient.
- Charges for mechanical devices designed to replace human organs, except for the use of a mechanical heart to keep a patient alive until a human donor heart becomes available, or a kidney dialysis machine.
- Charges incurred for keeping a donor alive for a transplant operation.
- CIGNA LIFESOURCE Transplant Network® Facility charges for personal comfort or convenience items.

PRESCRIPTION DRUGS

The Prescription Drug benefits shown below are subject to all of the terms, conditions and limitations contained in this Plan.

Pharmacy Payments

Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the annual medical Deductible and, once the Deductible is satisfied, subject to any applicable Copay or Percentage Copayment shown in the Schedule of Benefits.

Cigna's Prescription Drug List is available upon request by calling the Member Services number on Your ID card or on www.myCigna.com.

In the event that the Member request a Brand-name drug that has a generic equivalent, the Member will be financially responsible for the amount by which the cost of the Brand-name drug exceeds the cost of the generic drug, plus the Brand-name generic Copay or Percentage Copayment shown in the Schedule of Benefits.

The Member's responsibility for covered Prescription Drugs and Related Supplies will always be the lowest of:

- the Copay or Percentage Copayment for the Prescription Drug, or
- Cigna's discounted rate for the Prescription drug; or
- the Pharmacy's usual and customary (U&C) charge for the Prescription Drug.

Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers, regardless of the customer's payment source.

Services and Benefits

Subject to the provisions of this Plan, Cigna will cover those Medically Necessary Prescription Drugs and Related Supplies, ordered by a Physician and purchased from Participating Pharmacies as designated by Cigna. Cigna will also cover Medically Necessary Prescription Drugs and Related Supplies dispensed by a Participating Pharmacy, with a prescription issued to a Member by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When a Member is issued a prescription for a Medically Necessary Prescription Drug or Related Supply as part of the rendering of Emergency Services and a Participating Pharmacy cannot reasonably fill such prescription, such prescription will be covered by Cigna, subject to the provisions of this Plan.

Covered Prescription Drugs include, but are not limited to:

- Outpatient Drugs and medications that Federal and/or applicable State law restrict to sale by Prescription only, except for Insulin which does not require a prescription.
- Pharmaceuticals to aid smoking cessation.
- Insulin (no prescription required); syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.
- Self-Administered Injectable Drugs, and syringes for the self-administration of those Drugs.

- Orally administered anti-cancer medications prescribed in connection with cancer chemotherapy treatments.
- All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.
- Contraceptive Drugs and devices approved by the FDA.
- Specialty Medications are covered.
- Charges for a drug prescribed for the treatment of a covered chronic, disabling or life-threatening Illness, when that drug is Food and Drug (FDA) approved for at least one indication and is recognized for treatment in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or supported by articles in accepted, peer-reviewed medical literature. Any medical services necessary to administer the drug are covered under the medical benefits of this Plan.

Conditions of Service

The Drug or medicine must be:

- Prescribed in writing by a Physician and dispensed within one year of being prescribed, subject to Federal or state laws.
- Approved for use by the Food and Drug Administration.
- For the direct care and treatment of the Member's Illness, Injury or condition; however dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Physician for the care and treatment of a Member illness.
- Purchased from a licensed retail Pharmacy or ordered by mail through the mail-order Pharmacy program.
- The Drug or medicine must not be used while the Member is inpatient in any facility.
- The Prescription must not exceed the days' supply indicated in the "Limitations" section below.
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification.

Exclusions

Except as otherwise set forth in this "Prescription Drugs" section, coverage for Prescription Drugs and Related Supplies is subject to the exclusions and limitations set forth in the "Exclusions and Limitations" Section of the Plan. In addition, any services or benefits related to Prescription Drugs and Related Supplies, which are not described in this "Prescription Drugs" section, are excluded from coverage. By way of example, but not of limitation, the following are specifically excluded services and benefits:

1. Drugs not approved by the Food and Drug Administration;
2. Drugs available over the counter that do not require a prescription by Federal or State Law except as stated in this Plan, or specifically required by the Patient Protection and Affordable Care Act PPACA);
3. Drugs that do not require a Federal Legend (a Federal designation for drugs requiring supervision of a Physician), other than Insulin;
4. Any drug that is a pharmaceutical alternative to an over-the-counter drug other than Insulin;
5. A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee; except for

prescription contraceptives and tobacco cessation drugs;

6. Injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs are covered under the medical benefits of this plan and require Prior Authorization. The following are examples of Physician supervised injectable drugs: injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
7. Infertility related drugs, except those required by the Patient Protection and Affordable Care Act (PPACA);
8. Any drugs that are experimental or investigational, within the meaning set forth in the Plan;
9. Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized as safe and effective for the treatment of the particular indication in one of the standard reference compendia (drug information for the healthcare provider, The United States Pharmacopoeia Drug Information, or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
10. Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug, and the Medically Necessary services associated with the administration of the drug, are recognized as safe and effective for the treatment of the Member's specific cancer in at least one standard medical reference compendia or medical literature. Standard medical reference compendia include: The American hospital formulary service drug information; The National Comprehensive Cancer Network Drugs and Biologics Compendium; Thomson Micromedex Compendium DrugDex, Elsevier Gold Standard's Clinical Pharmacology Compendium; Other Authoritative Compendia as identified by the Secretary of the United States Department of Health and Human Services;
11. Implantable contraceptive products inserted by the Physician are covered under the plan's medical benefits;
12. Prescription and non-prescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies; except for those pertaining to Diabetic Supplies and Equipment;
13. Prescription vitamins other than pre-natal vitamins, dietary supplements, herbal supplements and fluoride other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);
14. Drugs used for cosmetic purposes that have no medically acceptable use, such as, drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
15. Injectable of Infused Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions are covered under the medical benefits of the plan;
16. Medications used for travel prophylaxis, except anti-malarial drugs;
17. Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Member's condition. Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances;
18. Drugs obtained outside the United States;
19. Replacement of Prescription Drugs and Related Supplies due to loss or theft;

20. Drugs used to enhance athletic performance;
21. Drugs which are to be taken by or administered to a Member while the Member is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
22. Prescriptions more than one year from the original date of issue.

Limitations

Each Prescription Order or refill shall be limited as follows:

- Up to a 90-day supply, at a Participating retail Pharmacy, for Preferred Generic, Non-Preferred Generic, Preferred Brand, Non-Preferred Brand, and Up to a 30-day supply of Specialty medications unless limited by the drug manufacturer's packaging: or
- Up to a 90-day supply, at a Participating mail-order Pharmacy, for Preferred Generic, Non-Preferred Generic, Preferred Brand, Non-Preferred Brand, and Up to a 30-day supply of Specialty medications unless limited by the drug manufacturer's packaging.
- Infusion and Injection Specialty Prescription Medications may require Prior or precertification.
- To a dosage and/or dispensing limit as determined by the P&T Committee.
- Managed drug limits (MDL) may apply to dose and/or number of days' supply of certain drugs; managed drug limits are based on recommendations of the federal Food and Drug Administration (FDA) and the drug manufacturer.

All newly approved drugs by the Food and Drug Administration (FDA) are designated as Non-Prescription Drug List drugs until the P & T Committee clinically evaluates the prescription drug product The P&T Committee reviews all FDA approvals within six months of a product being launched to the market. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug product. Prescription Drug Lists (formularies) are created in conjunction with a P&T Committee and business decision team to offer affordable and comprehensive options.

Prescription Drug Formulary Information

Prescription Drug benefits in this Plan are based on a Drug Formulary (also called the Prescription Drug List). This is a specific listing, developed by Cigna to identify and promote the appropriate prescribing of Prescription Drugs which are both therapeutically appropriate and cost effective choices.

The Pharmacy and Therapeutics (P&T) Committee regularly reviews new and existing Prescription Drugs to determine which are clinically effective and safe. Once Cigna's Clinical Pharmacy Team has received the recommendations of the P&T Committee, the Prescription Drug Lists are developed and drugs are added and removed accordingly.

The Prescription Drug List is reviewed 4 times a year, and updated as follows:

- changes in coverage such as adding new Drugs to the Prescription Drug List and moving Drugs to lower-cost tiers, are made on an ongoing basis.
- changes such as removing Drugs from the Prescription Drug List, or determining Drugs require Step Therapy are made once each Year on the Plan renewal date.

How to find out if a specific Prescription Drug is on the Prescription Drug List:

We will inform You, upon Your request, if a drug is included on the Prescription Drug List within 3 business days. To make a request, You can call Customer Service at the phone number on Your ID card or You can also view the Prescription Drug List at www.cigna.com/ifp-drug-list.

Please note: the inclusion of a drug in Cigna's Prescription Drug List does not guarantee that Your Physician will or must prescribe that drug for a particular medical condition or mental Illness.

Changes to Prescription Drug Formulary:

If a drug is removed from Cigna's Prescription Drug List during the Year, and You are taking that drug, We will make the drug available to You at the preferred benefit level through the end of the Year.

Pharmacy Formulary Exception Process / Prior Authorization Coverage of New Drugs

Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If the Member's Physician believes non-Prescription Drug List Prescription Drug or Related Supplies are necessary, or wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request a Prescription Drug List exception or Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician can certify in writing that the Member has previously used an alternative non-restricted access drug or device and the alternative drug or device has been detrimental to the Member's health or has been ineffective in treating the same condition and, in the opinion of the prescribing Physician, is likely to be detrimental to the Member's health or ineffective in treating the condition again. The Physician should make this request before writing the prescription.

If the request is approved, The Physician will receive confirmation. The Prior Authorization will be processed in Cigna's claim system to allow the Member to have coverage for those Prescription Drugs or Related Supplies. The length of the Prior Authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When the Physician advises the Member that coverage for the Prescription Drugs or Related Supplies has been approved, the Member should contact the Pharmacy to fill the prescription(s).

If the request is denied, the Physician and the Member will be notified that coverage for the Prescription Drugs or Related Supplies was not authorized.

If the Member disagrees with a coverage decision, the Member may appeal that decision in accordance with the provisions of this Plan, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If the Member has questions about specific Prescription Drug List exceptions or a Prior Authorization request, the Member can call Member Services at the toll-free number on their ID card.

Reimbursement/Filing a Claim

When a Member purchases Prescription Drugs or Related Supplies through a retail Participating Pharmacy they pay any applicable Copay or Deductible shown in the Schedule of Benefits at the time of purchase. The Member does not need to file a claim form.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see the mail-order drug introductory kit for details, or contact member services for assistance.

Claims and Customer Service

Drug claim forms are available upon written request to:

For Retail Pharmacy claims:
Cigna Pharmacy Service Center
P.O. Box 188053
Chattanooga TN 37422-8053

For mail-order Pharmacy claims:
Cigna Home Delivery Pharmacy
P.O. Box 1019
Horsham PA 19044-1019
1-800-835-3784

Forms are also available online at myCigna.com.

If the Member has any questions about the Prescription Drug benefit, they can call the toll-free customer service number on the back of their ID card**.**

PEDIATRIC VISION CARE

Note: Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit

Definitions

Pediatric Frame Collection means designated frames that are adequate to hold lenses, and are covered in full under Essential Healthcare Benefits.

Pediatric Vision Services means routine vision care examinations, preventive treatment and other services or treatment described in the "Pediatric Vision Services" section of this Plan provided to a Member who is under age 19.

Pediatric Vision Benefits

Please be aware that the Pediatric Vision network is different from the network of your medical benefits.

Covered Pediatric Vision Benefits are subject to any applicable Percentage Copayments shown in the Benefit Schedule.

What is Covered

In-Network Covered Benefits for a Member who is under age 19 include:

- Examinations – One vision and eye health evaluation by an Optometrist or an Opthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.
- Lenses (Glasses) – One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms).
  - Polycarbonate lenses
  - Scratch-coating
  - Oversize lenses;
  - Solid and gradient tints.
- Frames – One frame for prescription lenses from Pediatric Frame Collection. Only frames in the Pediatric Frame Collection are covered.
- Medically Necessary and Therapeutic Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens Materials as well as the cost of supplemental contact lens professional services including fitting and evaluation.
- Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction are not covered.
- Low Vision Coverage: Supplemental professional low vision services and aids are covered in full once every 24 months for a Member with partial sight, or whose sight is not fully correctable with surgery, pharmaceuticals, contact lenses or glasses. There are various low vision aids, such as the bioptic telescope, which can aid the Member with their specific needs.

Please be aware that not all contracted vision care providers provide all vision care services as part of their practice. Please check with the provider to verify that he or she offers the services you wish to receive under his/her Cigna participating provider agreement.

Exclusions

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any injury or Illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges incurred after the Plan ends or the Member's coverage under the Plan ends, except as stated in the Plan.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "What's Covered" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lens treatments, "add ons", or lens coatings not otherwise listed in "What's Covered." within this section.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- Prescription sunglasses.
- High Index lenses of any material type.
- For or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
- Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.
- Frames that are not in the designation Pediatric Frame Collection are not covered
- Elective contact lenses are not covered

Limitations

No payment will be made for expenses incurred for:

- more than one examination and one pair of lenses during a calendar year; or more than one pair of frames during a calendar year for any one person.
- medical or surgical treatment of the eye;
- lenses which are not medically necessary and are not prescribed by an Optometrist or Ophthalmologist, or frames for such lenses;
- care not listed in The Schedule;
- Other Exclusions and Limitations listed in this Plan

In addition, these benefits will be reduced so that the total payment under the items below will not be more than: 100% of the charge made for the vision service if the benefits are provided for that service under:

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by an Employer.

Cigna Vision Providers

To find a Cigna Vision Provider, or to get a claim form, the Member should visit **myCigna.com** and use the link on the vision coverage page, or they may call Member Services using the toll-free number on their identification card.

Reimbursement/Filing a Claim

When a Member(s) has an exam or purchases Materials from a Cigna Vision Provider they pay any applicable Copayment, Percentage Copayments or Deductible shown in the Schedule at the time of purchase. The Member does not need to file a claim form.

If a Member(s) has their exam or purchases Materials from a provider who is not a Cigna Vision Provider, the Member pays the full cost at the time of purchase. The Member must submit a claim form to be reimbursed. Send a completed Cigna Vision claim form and itemized receipt to:

Cigna Vision
Claims Department
PO Box 385018
Birmingham, AL 35238-5018

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

If You or Your Family Member(s) have any questions about the Pediatric Vision benefit, call the toll-free customer service number on the back of Your ID card.

PLAN EXCLUSIONS AND LIMITATIONS

Exclusions

No coverage is provided under this Plan for any Service or Supplies that are (i) not described as covered in the Schedule of Benefits, Services and Benefits section, or (ii) are specifically excluded in the Services and Benefits section.

In addition, the following are specifically excluded Services and Supplies:

1. Care for health conditions that has not been provided by, or provided by referral from, Your PCP or has not been authorized by Your PCP or the Cigna Medical Director, except for immediate treatment of a Medical Emergency/Emergency Medical Condition.
2. Care or Services received before the effective date of Your coverage under this Plan, except as approved under the Continuity of Care provision.
3. Care or Services received after the date Your coverage under this Plan ends.
4. Care or Services that are not Medically Necessary;
5. Any services provided by a local, state or federal government agency, except (a) when payment under this Plan is expressly required by federal or state law; or (b) services provided for the treatment of mental or nervous disorders by a tax supported institution of the State of Texas.
6. Care required by state or federal law to be supplied by a public schools system or school district.
7. If the Member is eligible for Medicare part A, B or D, Cigna will provide claim payment according to this Plan minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if the Member was not eligible for Medicare.
8. Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
9. Conditions caused by: (a) an act of war (declared or un-declared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) a Member participating in the military service of any country; (d) a Member participating in an insurrection, rebellion, or riot; (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a felony (whether or not charged) or as a direct result of the Member being engaged in an illegal occupation.
10. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Member does not claim those benefits.
11. Services for which You have no legal obligation to pay or for which no charge would be made if You did not have health plan or insurance coverage, except to the extent that the availability of insurance or health plan coverage may be considered by a tax supported institution of the State of Texas providing treatment of mental Illness or mental retardation to determine if a patient is non-indigent, as provided in Article 3196a of Vernon's Texas Civil Statutes.
12. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Plan.
13. Custodial care.
14. Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

15. Care, services, supplies or treatment for health conditions received or purchased directly or on Your behalf by anyone, including a Physician, from any of the following:
    - Yourself or Your employer;
    - a person who lives in the Member's home, or that person's employer;
    - a person who is related to the Member by blood, marriage or adoption, or that person's employer.

    This does not apply to covered dental services provided by a dentist licensed in the state of Texas and operating within the scope of his or her licensure.
16. Any services and supplies for or in connection with Experimental, Investigational or Unproven services.
17. Cosmetic surgery, therapy or surgical procedures primarily for the purpose of altering appearance (except as provided in the definition of Reconstructive Surgery or the description of the Reconstructive Surgery benefit in this Plan);
18. The following services, regardless of clinical indications;
    - macromastia or gynecomastia surgeries
    - abdominoplasty;
    - panniculectomy;
    - rhinoplasty;
    - blepharoplasty;
    - redundant skin surgery;
    - removal of skin tags;
    - acupressure;
    - craniosacral/cranial therapy;
    - dance therapy, movement therapy;
    - applied kinesiology;
    - rolfing;
    - prolotherapy; and
    - extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
19. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition.
20. Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Plan under "Pediatric Vision".
21. An eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
22. Any medical and surgical services for the treatment or control of obesity that are not included under the "Services and Benefits" section of this Plan;
23. Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex including medical or psychological counseling and hormonal therapy in preparation for, or

subsequent to, any such surgery. This also includes any medical, surgical or psychiatric treatment or study related to sex change.

24. Unless specifically covered under “Services and Benefits,” reports, evaluations, physical examinations, or hospitalization not required for health reasons including, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.

25. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise specifically covered under "Services and Benefits."

26. All services related to infertility once diagnosed, including but not limited to, infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees); Cryopreservation of donor sperm and eggs are also excluded from coverage.

27. Reversal of male and female voluntary sterilization procedures.

28. Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Plan.

29. The following are not covered for treatment of Mental Health or Substance Use Disorder: Any court-ordered treatment or therapy or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this Plan; Special education, including but not limited to, school tuition; Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain or of chronic conditions not subject to favorable modification according to generally accepted standards of medical practice; Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders; Counseling for borderline intellectual functioning, or related to consciousness-raising or of an educational, vocational or religious nature; I.Q. testing; Wilderness programs, animal therapy programs; Residential treatment (unless associated with a Substance Use Disorder as defined by this Plan; marriage counseling; Custodial Care, including but not limited to geriatric day care; Psychological testing on children requested by or for a school system; Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline; Biofeedback.

30. Non-medical counseling or ancillary services including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, or mental retardation, except otherwise specifically covered in this Plan.

31. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected, except as specifically stated in this Plan.

32. Educational services except for Diabetes Self-Management Training; counseling/ educational services for breastfeeding; physician counseling regarding alcohol misuse, preventive medication, obesity, nutrition, tobacco cessation and depression; preventive counseling and educational services specifically required under Patient Protection and Affordable Care Act (PPACA) and as specifically provided or arranged by Cigna.

33. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services", "Outpatient Facility Services", "Home Health Services", Diabetic Services and Supplies", or "Breast Reconstruction and Breast Prostheses" sections of the "Services and Benefits" section.

34. Private hospital rooms and/or private duty nursing except as provided in the "Home Health Services" section of "Services and Benefits.", or when deemed medically appropriate by Us. Private duty nursing will not be excluded in an inpatient setting, if skilled nursing is not available.

35. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of Illness or injury.

36. Orthopedic shoes (except when joined to braces), shoe inserts, foot orthodic devices except as required by law for diabetic patients.

37. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, orthotics, elastic stockings, garter belts, corsets, dentures and wigs, except as provided in "Services and Benefits" section of the Plan.

38. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.

39. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery and pediatric vision).

40. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy, except for pediatric vision.

41. Treatment by acupuncture.

42. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

43. Items which are furnished primarily for personal comfort or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.).

44. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.

45. Dental implants for any condition.

46. Dental services, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Plan.

47. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Cigna Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

48. Blood administration for the purpose of general improvement in physical condition.

49. All nutritional supplements and formulas are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.

50. All vitamins and medications and contraceptives available without a prescription ("over-the-counter") except for those covered under mandate of the 2010 Patient Protection and Affordable Care Act (PPACA).

51. Expenses incurred for or in connection with an injury or Illness arising out of, or in the course of, any employment for wage or profit.

52. Telephone, email and internet consultations, except for benefits described in "Telehealth and Telemedicine Medical Services".

53. Massage therapy.

54. All non-prescription Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription; Injectable drugs ("Self-administered Injectable" drugs) that do not require Physician supervision; All non-injectable Prescription Drugs, Injectable Drugs that do not require Physician supervision and are typically considered Self-administered Injectable Drugs, non-prescription drugs, and investigational and experimental drugs, and Self-administered injectable Drugs, except as stated in the Schedule of Benefits and in the Prescription Drug section of this Plan.

55. Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision, except as otherwise stated in this Plan, if not provided by an approved Participating Provider specifically designated to supply that specialty prescription. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intraveneous immunoglobulin.

56. Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Member's condition. Growth hormone treatment for idiopathic short stature or improved athletic performance is not covered under any circumstances.

57. Charges for which We are unable to determine Our liability because the Member failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.

58. Charges for the services of a standby Physician.

59. Charges for animal to human organ transplants.

60. Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

Limitations

Circumstance Beyond the Cigna HMO Plan's Control. To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within Our control results in Our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Plan, We will make a good faith effort to provide or arrange for the provision of the service or supplies, taking into account the impact of the event.

WHEN YOU HAVE A COMPLIANT OR AN APPEAL

When You Have a Complaint or an Appeal of an Adverse Determination

(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’re here to listen and help. We want you to be completely satisfied with this Plan and the care you receive. That’s why We’ve established a process for addressing your concerns and solving your problems. If you are dissatisfied about any aspect of your Plan’s operation, or have a concern regarding rescission of coverage, you can call the toll-free number on Our Cigna HealthCare ID card and explain your situation to one of Our Member Services representatives. You can also express that concern by walk-in interview, arranged appointment, or in writing at the following:

Cigna HealthCare of Texas, Inc.
National Appeals Unit
P.O. Box 188011
Chattanooga, TN 37422

Member Services Toll-Free Number appears on your Cigna HealthCare ID card

The process which We will use to address your concern depends on the nature of your issue. If you are dissatisfied about any aspect of the Plan’s operation other than an issue related to Medical Necessity or a rescission of coverage, your concern is considered to be a Complaint and would follow the “Complaints and Complaint Appeals Process”. For issues related to Medical Necessity or a rescission of coverage, your concern is considered to be an Adverse Determination and would follow the “Adverse Determination Appeal Process”.

Complaints and Complaint Appeals Process

Complaints

Complaints include dissatisfaction with plan administration procedures, denial, reduction, or termination of a service for reasons not related to Medical Necessity, disenrollment decisions or the way a service is provided. A Complaint does not include: (a) a misunderstanding or problem of misinformation which We can resolve by clearing up the misunderstanding or by supplying the correct information to your satisfaction; or (b) you or your provider’s dissatisfaction or disagreement with an Adverse Determination.

You may notify Us of your Complaint orally or in writing. We will send you a letter acknowledging the date on which We received your Complaint no later than the 5th business day after We receive your Complaint. If you notify Us of your Complaint orally, We will send you a one-page Complaint form that you must return to Us for prompt resolution of the Complaint.

We’ll get back to you with a decision in writing, as soon as possible. If the Complaint relates to a prospective or concurrent care coverage determination which requires prior authorization under the plan and your Complaint is filed before you receive the service, We will respond with a decision within fifteen (15) calendar days after We receive your Complaint. For all other issues, We will respond with a decision within thirty (30) calendar days after We receive your Complaint.

You may request that the Complaint Process be expedited, if: (a) the time frames under the Complaint Process would seriously jeopardize your life, health, or ability to regain maximum functionality, or, in the opinion of your treating physician would cause you severe pain, which cannot be managed without the requested services; or (b) your Complaint involves non-authorization of an admission or a continuing inpatient stay.

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

Cigna's Medical Director, or your treating physician, will decide if it is necessary to expedite the Complaint Process. When the Complaint Process is expedited, We will respond orally with a decision based upon the medical or dental immediacy of the case, within one (1) business day or sooner from the date We receive your request. We will follow up in writing within two (2) calendar days.

If you are not satisfied with the Complaint resolution decision, you can start the Complaint Appeal Process.

Complaint Appeals

If We do not resolve your Complaint to your satisfaction, you have the right to appeal Our decision to Our Complaint Appeal Panel. You may appeal by appearing in person, telephonically, or by other technological means before the Complaint Appeal Panel or by presenting a written appeal to the Complaint Appeal Panel. The Complaint Appeal Panel will meet in the Service Area where you normally receive health care services, unless you agree to another location. When you appeal your Complaint:

1. We will send an acknowledgment letter to you within five (5) business days after the date We receive your request for a Complaint Appeal.
2. We will appoint individuals to form a Complaint Appeal Panel. The Complaint Appeal Panel will advise Us on the resolution of the Complaint Appeal. The Complaint Appeal panel will include an equal number of: (a) Our staff; (b) physicians or other providers; and (c) enrollees. No members of the Complaint Appeal Panel will have been involved with prior decisions related to your issue.
3. We will send you copies of any documentation which We plan to present to the Complaint Appeal Panel no later than the fifth (5^{th}) business day before the Complaint Appeal Panel is scheduled to meet. We will also send you the specialization of any physician or providers with whom We consulted during Our investigation of your Complaint and the names and affiliations of each of Our staff members who will serve on the Complaint Appeal Panel. In the event any new or additional information (evidence) is considered, relied upon or generated by the Plan in connection with the Complaint Appeal, the Plan will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by the Plan, We will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.
4. We will notify you of the Complaint Appeal Panel's decision no later than the fifteenth (15^{th}) calendar day after We receive your Complaint Appeal request if the issue relates to a prospective or concurrent coverage determination which requires prior authorization under the plan and you filed your Complaint Appeal before the service is rendered. We will respond no later than the thirtieth (30^{th}) calendar day after We receive your Complaint Appeal request for any other issue.

The investigation and resolution of an expedited complaint appeal shall be concluded:

1. in accordance with the medical or dental immediacy of the case; and
2. not later than one (1) business day after We receive Your request for appeal.

Appeal Involving Ongoing Emergency or Continued Hospitalization

The investigation and resolution of an appeal of a complaint relating to an ongoing emergency or denial of continued hospitalization shall be concluded:

1. in accordance with the medical or dental immediacy of the case; and
2. not later than one (1) business day after We receive Your request for appeal is received.

Because of the ongoing emergency or continued hospitalization and at Your request, Cigna shall provide, instead of a complaint appeal panel, a review by a Physician or provider who:

3. has not previously reviewed the case; and
4. is of the same or a similar specialty as the Physician or provider who would typically manage the medical condition, procedure, or treatment under consideration for review in the appeal.

The Physician or provider reviewing the appeal may interview You or Your designated representative and shall decide the appeal.

The Physician or provider may deliver initial notice of the decision on the appeal orally if the Physician or provider subsequently provides written notice of the decision not later than the third (3rd) day after the date of the decision.

The investigation and resolution of an appeal after emergency care has been provided shall be conducted in accordance with the procedures otherwise established under Texas law, including the right to review by a complaint appeal panel.

Adverse Determination Appeals and Independent Review of Adverse Determinations

Adverse Determination Appeals

An Adverse Determination is a determination made by the Plan that the health care services provided or proposed to be provided to you are not Medically Necessary or are experimental or investigational. An Adverse Determination also includes a denial by the Plan of a request to cover a specific prescription drug prescribed by your Physician; or a rescission of coverage.

If you do not agree with the Adverse Determination, you, or a person acting on your behalf, may appeal the Adverse Determination orally or in writing. We will consider your expression of dissatisfaction or disagreement as an appeal of the Adverse Determination. We will acknowledge Our receipt of your Adverse Determination Appeal in writing within five (5) business days after We receive your Adverse Determination Appeal. If you notify Us orally of your Adverse Determination Appeal, We will send you a one-page Adverse Determination Appeal form that you may use to provide Us with additional information.

Your Adverse Determination Appeal will be reviewed and the decision will be made by a health care professional who was not involved in the initial Adverse Determination and who is in the same or similar specialty that typically manages the medical or dental condition, procedure or treatment under review. In the event any new or additional information (evidence) is considered, relied upon or generated by the Plan in connection with the Adverse Determination Appeal, the Plan will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by the Plan, We will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. We will respond in writing with a decision within thirty (30) calendar days after We receive the request for an Adverse Determination Appeal.

You may request that the Adverse Determination Appeal Process be expedited if: (a) the time frames under the Adverse Determination Appeal Process would seriously jeopardize your life, health, or ability to regain maximum functionality or, in the opinion of your treating physician, would cause you severe pain, which cannot be managed without the requested services; or (b) the Adverse Determination involves non-authorization of an admission or a continuing inpatient stay. If you request that your Adverse Determination Appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal Adverse Determination Appeal would be detrimental to your medical condition.

Cigna's Medical Director, or your treating physician, will decide if an expedited Adverse Determination Appeal is necessary. When an Adverse Determination Appeal is expedited, We will respond orally with a decision within one (1) business day or sooner from the date We receive your request. We will follow up in writing within two (2) calendar days.

Independent Review Process for Adverse Determinations Appeals

The Texas Department of Insurance oversees an Independent Review Process for Adverse Determination Appeals involving issues related to prospective, concurrent or retrospective utilization review determinations. If you are not fully satisfied with the Adverse Determination Appeal decision, you may request that your Adverse Determination Appeal be referred to an Independent Review Organization for review. You may request an Independent Review of an Adverse Determination without completing the Plan's Adverse Determination Appeal Process if you feel your condition is life-threatening.

The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates and the Independent Review Organization is completely separate from the Plan. A decision to use the Independent Review Process will not affect your rights to any other benefits under the plan. There is no charge to initiate the Independent Review Process. We will provide you and your treating physician with the necessary forms to request an Independent Review when We make an Adverse Determination or when We make an Adverse Determination Appeal decision. If your condition is life threatening, you may contact Us by telephone to initiate the Independent Review Process. We will abide by the decision of the Independent Review Organization.

Right to Contact the State of Texas

You have the right to contact the Texas Department of Insurance (TDI) for assistance with your Complaint, Complaint Appeal or Adverse Determination Appeal at any time. You may also contact TDI if you do not believe We have complied with Texas regulations regarding the handling of Complaints, Complaint Appeals or Adverse Determination Appeals. TDI may be contacted at the following address and telephone number:

Texas Department of Insurance
333 Guadalupe Street
P.O. Box 149104
Austin, Texas 78714-9104

800.252.3439 (toll-free telephone number)
(512) 490-1007 (facsimile number)

www.tdi.texas.gov (email)

Contents of Complaint, Complaint Appeal and Adverse Determination Appeal Notices
Every notice of a Complaint, Complaint Appeal and Adverse Determination Appeal decision will be provided in writing or electronically and will include:

(1) information sufficient to identify the claim;

(2) the specific medical or contractual reason or reasons for the denial decision;

(3) the specialty of any physician or health care provider consulted in making the denial decision;

(4) reference to the specific plan provisions on which the decision is based;

(5) 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;

(6) 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) if the plan is governed by ERISA;

(7) a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the Complaint, Complaint Appeal or Adverse Determination Appeal decision, including 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;

(8) instructions for filing complaints with the Texas Department of Insurance; and

(9) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an Adverse Determination Appeal will include a discussion of the decision.

If your Complaint or your Adverse Determination Appeal is expedited, you do not need to complete the Complaint or Adverse Determination Appeal process prior to bringing legal action.

Relevant Information

Relevant Information is any document, record, or other information which was: (a) 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 for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Retaliatory Action Prohibited

The Plan may not engage in retaliatory action, including refusal to renew or cancellation of coverage, against the Member because the Member, or a person acting on behalf of the Member, has filed a complaint against the Plan or appealed a decision of the Cigna Medical Director. The Pan may not engage in retaliatory action, including a refusal to renew or termination of the Agreement, against a Physician or Participating Provider because the Physician or Participating Provider has, on behalf of the Member, reasonably filed a complaint against the Plan or appealed a decision of the Cigna Medical Director.

RELATION OF THE PLAN TO OTHER SOURCES OF PAYMENT FOR HEALTH SERVICES

Subrogation

If You are injured or rendered ill under circumstances which create a liability for a third party to pay claims or damages to You, We are subrogated to all rights, claims, or interests which You may have against such third party.

To the extent permitted by law, We may recover from the third party the cost of the care which We have provided for You; and

We have the right to recover from the third party to the extent of payments that We have paid for services and supplies and not rendered services. If permitted by applicable state or federal law, We may require You, Your guardian, personal representative, estate, Dependents, or survivors, as appropriate, to assign Your claim or cause of action against the third party to Us and to execute and deliver such instruments to secure Our right to that claim.

Coordination of Benefits

The Coordination of Benefits (COB) provision applies when a Member has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. **The plan that pays first is called the primary plan**. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. **The plan that pays after the primary plan is the secondary plan.** The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

Definitions

(a) A **"plan"** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that

pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage under (a)(1) or (a)(2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

(b) **"This plan"** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense

(c) **"Allowable expense"** is a health care expense, including deductibles, percentage copayments, and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care provider's or physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

(d) **"Allowed amount"** is the amount of a billed charge that a carrier determines to be covered for services provided by a non-preferred health care provider or physician. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or percentage copayments amounts for which the member is responsible.

(e) **"Birthday",** for the purposes of coordination of benefits, refers only to the month and day in a Calendar Year, and does not include the Year in which the individual was born.

(f) **"Carrier"** is an entity authorized under the Texas Insurance Code to provide coverage subject to Subchapter V, 28 TAC 3.501-3.510, including an insurer, health maintenance organization, group hospital service corporation, or stipulated premium company.

(g) **"Certificate Holder"** is a member or enrollee who is covered other than as a dependent under a group plan or a group-type plan.

(h) **"Claim"** is a request that benefits be provided or paid. The benefits claimed may be in the form of:

a) Services, including supplies;

b) Payment for all or a portion of the expenses incurred;

c) A combination of a) and b); or

d) An indemnification.

(i) **"Closed Panel Plan"** is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.

(j) **"Consolidated Ominbus Budget Reconciliation Act of 1985 (COBRA)"** is coverage provided under a right of continuation under federal law.

(k) **"Contract"** refers to an insurance policy, insurance certificate, or health maintenance organization evidence of coverage.

(l) **"Coordination of Benefits (COB)"** is A provision establishing an order in which plans pay their claims and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

(m) **"Custodial parent"** is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

(n) **"Group type Contract**" is a contract that is not available to the public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage.

(o) **"High-deductible Health Plan"** is a high-deductible health plan under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and Insurance Code Chapter 1653.

(p) **"Hospital Indemnity Benefits"** are benefits not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the member the right to elect indemnity-type benefits at the time of claim.

Order of Benefits Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan. A plan is primary if:

a. the plan either has no order of benefit determination rules, or its rules differ from those permitted by this subchapter; or

b. all plans that cover the person use the order of benefit determination rules required by this subchapter, and under those rules, the plan determines its benefits first.

(b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this Plan is always primary unless the provisions of both plans state that the complying plan is primary.

(c) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(d) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

(e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a non-contracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(f) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

(g) A secondary plan is any plan that is not the primary plan.

(h) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

(i) Each plan determines its order of benefits using the first of the following rules that apply.

1) Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.

2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(B) For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

(i) if a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

(ii) if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.

(iv) if there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) the plan covering the custodial parent;

(II) the plan covering the spouse of the custodial parent;

(III) the plan covering the noncustodial parent; then

(IV) the plan covering the spouse of the noncustodial parent

(C) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

(D) For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, (h)(5) applies.

(E) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's spouse.

3) Active, Retired, or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

5) Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of this Plan

(a) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(b) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with Federal and State Laws Concerning Confidential Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Organization responsible for COB administration will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give Organization responsible for COB administration any facts it needs to apply those rules and determine benefits

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Organization responsible for COB administration may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Organization responsible for COB administration will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Organization responsible for COB administration is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Medicare Eligibles

Cigna will pay as the Secondary Plan for a Member as permitted by the Social Security Act of 1965 as amended.

Cigna will estimate the amount Medicare would have paid, and pay as secondary to that estimated amount, in the following circumstances:

- A Member who is eligible for Part B of Medicare, but is not enrolled.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for that person. This reduction will not apply to any Insured Person except as listed under "Cigna will pay as the Secondary Plan…"above.

Alternate Cost Containment Provision

We may, in certain situations, approve services under an alternate treatment plan. An alternate treatment plan may include services or supplies otherwise limited or excluded by the Plan. The alternate treatment plan must be mutually agreed to by Us, the Member, and the Physician, Provider, or Other Healthcare Practitioner. Our offering an alternate treatment plan in a particular case in no way commits Us to do so in another case, nor does it prevent Us from strictly applying the express benefits, limitations, and exclusions of the Plan at any other time or for the Member.

AMENDMENT OR MODIFICATION OF PLAN

Amendment or Modification by Cigna

The Plan may be amended or modified at the time of renewal by Cigna with at least 60 days' prior written notification to the Subscriber. Cigna Amendments are effective as of the date indicated in the Amendment.

Amendment or Modification by Law or Regulation

The provisions of the Plan are subject to the approval of all regulatory bodies of competent jurisdiction, and in the event that regulatory bodies request any amendment or modification of the Plan, such amendment or modification shall supersede the provisions of the Plan.

If any provision of this Plan which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

MISCELLANEOUS

How to File a Claim and How Claims Will be Paid

If You receive care from Non-Participating Providers, You must submit a claim to Us no later than sixty (60) days after the first service is provided. The claim must contain an itemized statement of treatment, expenses and diagnosis. The claim should be sent to the address on the back of Your Member Identification Card. This requirement shall not cause denial of an otherwise valid claim if You could not reasonably comply, provided You submit the claim and the itemized statement to Us as soon as reasonably possible.

No later than fifteen (15) days after We receive the claim, We will:

1) Acknowledge receipt of the claim;
2) Begin investigating the claim; and
3) Request any additional information, statements or forms deemed necessary. Additional requests may be made during the course of the investigation.

No later than fifteen (15) days after We receive all requested items and information, You will be notified of the acceptance or rejection of the claim or that additional time is needed. We will state the reason(s) if the claim is rejected or if additional time is needed. The claim will be accepted or rejected no later than forty-five (45) days after the date of notification of the additional time requirements.

The claim will be paid no later than five (5) days after notification of acceptance of the claim.

Cigna's Representations and Disclosures

1. Cigna HealthCare of Texas, Inc. (Cigna) is a for-profit health maintenance organization (HMO) which arranges for the provision of covered Services and Supplies through a network of Participating Providers. All Members will be provided with access to a Provider directory at enrollment without charge. The Provider directory includes a map and Zip Code listing of the Service Area and a list of Participating Providers. If You would like another Provider directory, please contact Member Services at the toll-free number found on Your Cigna HealthCare ID card or visit the Cigna HealthCare web site at myCigna.com.
2. With the exception of any employed Physicians who work in a facility operated by Cigna Health Care (so-called "staff model" providers), the Participating Providers are independent contractors. They are not the agents or employees of Cigna and they are not under the control of the Cigna HealthCare of Texas, Inc. or any Cigna company. All Participating Providers are required to exercise their independent medical judgment when providing care.
3. Cigna maintains all medical information concerning a Member as confidential in accordance with applicable laws and professional codes of ethics. A copy of Cigna's confidentiality policy is available upon request.
4. We do not restrict communication between Participating Providers and Members regarding treatment options.
5. Under federal law (the Patient Self-Determination Act), You may execute advance directives, such as living wills or a durable power of attorney for health care, which permit You to state Your wishes regarding Your health care should You become incapacitated.
6. Upon Your admission to a participating inpatient facility, a Participating Physician other than Your PCP may be asked to direct and oversee Your care for as long as You are in the inpatient facility. This Participating Physician is often referred to as an "inpatient manager" or "hospitalist." The decision regarding whether or not to utilize a hospitalist is between You and Your PCP. Usage of a hospitalist is not required under this Plan.
7. The terms of this Plan may be changed in the future either as a result of an amendment by the Cigna to comply with changes in law. The Subscriber may terminate this Plan as specified in the Plan.

Additional Programs/Non-Insurance Benefits

We offer or arrange for various entities to offer discounts, non-insurance benefits or other consideration to You for the purpose of promoting the general health and well-being of You and Your Family Members. Additional programs/non-insurance benefits and discounts included under Your Plan, and available for use by Members, include but are not limited to:

- 24-hour health information — You can call the Cigna HealthCare 24-Hour Health Information Line℠ any time to speak with a registered nurse or listen to Our audio library for health-related information. The goal of the Cigna HealthCare 24-Hour Health Information Line is to assist the Member in making educated health care choices. The program's objectives are:
    - to provide level-of-care recommendations (emergency, urgent, Physician, home/self-care) to the Member who call with symptom-based questions or concerns;
    - to provide up-to-date, evidence-based medical information in response to Your questions or concerns, with the intention of increasing the Members understanding of their individual physical condition and improving their health; and
    - to facilitate the Members' access to Physicians and facilities in the Cigna provider network.

- Member discounts — with Our Healthy Rewards® discount program, You can save up to 60% on products and services-from acupuncture to weight management To use the program, the Members' must have access to mycigna.com. As this is a discount program, and not a covered benefit, there are no doctor referral requirements and no limits to usage. Members simply pick a participating Healthy Rewards provider, present their Cigna ID card and pay the reduced fee. Some programs require registration directly with the outside entity/vendor prior to going to a provider for service.

Cost of services provided by other parties -- We arrange for the reimbursement of all or a portion of the cost of services provided by other parties.

These additional programs/non-insurance benefits are offered to You at no additional cost. We are responsible for any additional programs/non-insurance benefits administered by outside entities/vendors. To get more information regarding these additional programs/non-insurance benefits, You can go to mycigna.com or contact Our toll-free Customer Service phone number listed on Your Cigna ID card. You will be notified when these additional programs/non-insurance benefits and discounts are terminated under Your Plan. Contact Us for details regarding any such arrangements.

Relationships

The Subscriber enters into the Agreement on behalf of the eligible individuals enrolling under the Plan. Acceptance of the Agreement by the Subscriber is acceptance by and binding upon those who enroll as Members.

The relationship between Cigna and Participating Providers who are not employees of Cigna are independent contractor relationships. Such physicians, hospitals, and providers are not agents or employees of Cigna; and Cigna and its employees are not agents or employees of such physicians, hospitals or providers.

Notice

With respect to this Plan "Notice" means written notice which shall be hand-delivered or mailed through the United States Postal Service, postage prepaid, addressed to the latest address furnished to Cigna by Subscriber or by the Member. Notice is deemed received by the person to whom the document is addressed on the fifth business day after being mailed.

Entire Agreement

This Agreement constitutes the entire agreement between the parties. The Agreement supersedes any other prior Agreements between the parties. No agent or other person, except an officer of Cigna, has authority to waive any conditions or restrictions of the Agreement; extend the time for making payment; or bind Cigna by making any promise or representation, or by giving or receiving any information, except as otherwise provided under applicable law. No change in the Agreement shall be valid unless stated in an Amendment attached hereto signed by an officer of Cigna.

Severability

If any term, provision, covenant or condition of the Plan is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated.

No Implied Waiver

Failure by Cigna on one or more occasions to avail itself of a right conferred by the Agreement shall in no event be construed as a waiver of Cigna's right to enforce said right in the future.

Records

Cigna keeps records of all Members, but shall not be liable for any obligation dependent upon information from the Subscriber prior to its receipt in a form satisfactory to Cigna. Incorrect information furnished by the Subscriber may be corrected, if Cigna shall not have acted to its prejudice by relying on it. All records of the Subscriber and Cigna which have a bearing on coverage of Members hereunder shall be open for review by Members at any reasonable time.

Clerical Error

No clerical error on the part of Cigna shall operate to defeat any of the rights, privileges or benefits of any Member.

Conformity With State and Federal Statutes

If any provision of this Plan which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Incontestability

All statements made by the Subscriber on the application for enrollment are considered representations and not warranties. The statements are considered truthful and made to the best of the Subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel or non-renew a Member's coverage or reduce benefits under this Plan unless

- It is in a written enrollment application signed by the Subscriber; and
- A signed copy of the enrollment application is or has been furnished to the Subscriber or the Subscriber's personal representative.

An individual Agreement may only be contested because of fraud or intentional misrepresentation of material fact made on the application for enrollment.

Administrative Policies Relating to This Agreement

Cigna may adopt reasonable policies, procedures, rules and interpretations which promote orderly administration of this Agreement.

Cancellation

We may cancel this Agreement only in the event of any of the following:

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have made any intentional misrepresentations, committed, or allowed someone else to commit, any fraud or deception in connection with this Agreement or coverage, after Cigna provides 15 days' advance written notice; however an individual contract can only be contested because of fraud or intentional misrepresentation of material fact on the enrollment application.
5. When We cease to offer plans of this type to all individuals in Your class. In this event, Texas law requires that We do the following:
    a. provide written notice to each Member of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage;
    b. offer to each Member on a guaranteed issue basis the option to purchase any other individual hospital medical or surgical insurance coverage offered by Us at the time of discontinuation; and
    c. act uniformly without regard to any health status related factors of a Member.
6. When We cease offering any plans in the individual market in Texas, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. In the event of cancellation, We will promptly return the unearned portion of any premium paid:
    - If We cancel the Plan, the earned premium shall be computed pro rata. Cancellation is without prejudice to any claim originating before the effective date of cancellation.

The Subscriber may cancel this Plan after not less than 30 days written notice to the Cigna.

- If You cancel Your Plan, the earned premium shall be computed by use of the short-rate table last filed with the state official having supervision of insurance in the state where the member resided when the Plan was issued.

Any cancellation shall be without prejudice for any claim for Covered Expense incurred before cancellation.

Reinstatement

If this Plan cancels because You did not pay Your premium within the time granted You for payment, and if We, or an agent We have authorized to accept premium, then accepts a late premium payment from You without asking for an application for reinstatement, We will reinstate this Plan. However, if We require an application for reinstatement, We will only reinstate this Plan if We approve Your reinstatement application. We will otherwise notify You in writing that We have disapproved Your reinstatement application. If We require an application for reinstatement and give You a conditional receipt for Your late premium payment, We will only reinstate this Plan if either We approve Your

reinstatement application, or lacking such approval, upon the forty-fifth day following the date on Our conditional receipt if We have not by that date notified You in writing of Our disapproval of Your application.

If this Plan is reinstated, benefits will be provided only for an Accidental Injury that occurs after the date of reinstatement, or for an Illness that begins more than 10 days after the state of reinstatement. Otherwise, You and Cigna shall have the same rights as existed under the Plan immediately before the due date of the defaulted premium, subject to any amendments or endorsements attached to the reinstated Plan.

Any premiums accepted in connection with a reinstatement will be applied to a period for which You have not previously paid premium, but not to exceed sixty days prior to the date of reinstatement. There is a $50 service fee for reinstatement.

Access to Information Relating to Provider Services

Cigna is entitled to receive from any provider who renders service to a Member all information reasonably necessary to fulfill the terms of this Plan. Subject to applicable confidentiality requirements, each Member authorizes any provider rendering service to disclose all facts pertaining to such service, to render reports pertaining to such services or the Member's physical condition and to permit copying of records by Cigna.

Agreement Binding on Members

By electing health care coverage pursuant to this Agreement, or accepting services or benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions herein. However, this Agreement shall be subject to amendment, modification or termination in accordance with any provisions hereof, without the consent or concurrence of the Members.

Class Action Waiver:

Except as provided by Texas Insurance Code §§ 541.251 *et seq.*, You (including any legal representative acting on Your behalf) hereby expressly waive the right to participate, as a plaintiff or class member, in any purported class, collective, representative, multiple plaintiff or similar proceeding ("Class Action"). Except as provided by Texas Insurance Code §§ 541.251 *et seq*., You expressly waive the ability to maintain a Class Action in any forum. In the case of an arbitration, the Arbitrator shall not have authority to conduct a Class Action, combine or aggregate similar claims of an entity or person not a party to this agreement, or make an award to any person or entity not a party to this agreement.

Applications, Statements, etc.

Members or applicants for membership shall complete and submit to Cigna such applications or other forms or statements as Cigna may reasonably request. Members warrant that all information shown in such applications, forms or statements shall be true, correct and complete. All rights to benefits hereunder are subject to the condition that all such information shall be true, correct and complete.

Successors and Assigns

This Agreement shall be binding upon and shall inure to the benefit of the Successors and Assigns of Cigna, but shall not be assignable by any Member.

Fraud

If the Member has committed, or allowed someone else to commit, any fraud or deception in connection with this Agreement, then any and all coverage under this Agreement shall be void and of no legal force or effect after 15 days' advance notice from Cigna.

Identification Card

Cards issued by Cigna to Members pursuant to this Plan are for identification only. Possession confers no right to services or other benefits under this Plan. To be entitled to such services or benefits the holder must, in fact, be a Member on whose behalf all Charges and Member payments under this Plan have been paid.

SCHEDULE OF BENEFITS

The following is the Schedule of Benefits, including medical, prescription drugs and pediatric vision benefits. The Plan sets forth, in more detail, the rights and obligations of both You and Your Family Member(s) and the Plan. It is, therefore, important that all Members **READ THE ENTIRE PLAN CAREFULLY!**

Services for Out-of-Network providers are not covered except for initial care to treat and stabilize an Emergency Medical Condition. SERVICES FROM NON-PARTICIPATING PROVIDERS ARE NOT AVAILABLE EXCEPT AS DESCRIBED IN THE "EMERGENCY SERVICES" PROVISION OF THE "SERVICES AND BENEFITS" SECTION OR WITH THE PRIOR APPROVAL OF THE CIGNA MEDICAL DIRECTOR.

Members are entitled to receive the services and benefits set forth in this Schedule, subject to payment of Copayments, Percentage Copayment and any applicable Deductible as specified in the Schedule, and subject to the conditions, limitations and exclusions of this Plan.

Services that require Prior Authorization include, but are not limited to, inpatient Hospital services, inpatient services at any Other Participating Healthcare Facility, outpatient facility services, advanced radiological imaging, non-emergency ambulance, and Transplant Services. Prior authorization for non-emergency ambulance services may be obtained from a Participating Provider that is treating the Member.

Prior Authorization requirements for Prescription Drugs are detailed in the "Prescription Drugs" section of the Plan.

BENEFIT INFORMATION **Note:** **Covered Services are subject to Annual and any additional deductible(s)unless specifically waived.**	**IN-NETWORK PROVIDER** **(Based on Cigna Contract Allowance)** **YOU PAY:**
Medical Benefits	
Annual Deductible	**Deductible**
Individual	$3,200
Family	$6,400
Out-of-Pocket Maximum	
Individual	$5,400
Family	$10,800
	The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties and Policy Maximums.
Percentage Copayment	You and Your Family Members pay 20% of Charges after the Annual Deductible.

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BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s)unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Prior Authorization Program **Prior Authorization – Inpatient Services**	Your Participating Provider must obtain approval for inpatient admissions; or Your Provider may be assessed a penalty for non-compliance.
Prior Authorization – Outpatient Services **NOTE:** Please refer to the section on Prior Authorization of inpatient and outpatient services above for more information in Your Plan. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of Your ID card or at www.mycigna.com under "View Medical Benefits Details".	Your Participating Provider must obtain approval for certain outpatient procedures and services; or Your Provider may be assessed a penalty for non-compliance.
Preventive Care Services Please refer to "Preventive Care-Periodic Health Examinations" section of the Plan for additional details.	0% Deductible waived
Pediatric Vision Care Performed by an Ophthalmologist or Optometrist for a Member who is under age 19. Please be aware that not all contracted vision care providers provide all vision care services as part of their practice. Please check with the provider to verify that he or she offers the services you wish to receive under his/her Cigna participating provider agreement.	
Comprehensive Eye Exam (Limited to one exam per year)	0% Deductible waived
Pediatric Frames for Children (Limited to one pair per year)	0% Deductible waived
Eyeglass Lenses for Children (Limited to one pair per year) Single Vision, Lined Bifocal, Lined Trifocal Lenticular	0% Deductible waived
Contact Lenses and Professional Services for Children (Limited to one pair per year)	
Elective	0% Deductible waived
Therapeutic **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	0% Deductible waived

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s)unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Physician Services **Office Visit** ***Primary Care Physician (PCP)*** ***Specialist Physician*** *(including consultant, referral and second opinion services)* **NOTE:** if a Copayment applies for OB/GYN visits, the level of Copayment You pay will depend on how Your doctor is listed in the provider directory.	 $25 Copayment Deductible waived $75 Copayment Deductible waived
Physician Services, continued Surgery in Physician's office Outpatient Professional Fees for Surgery (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy) Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy In-hospital visits Allergy testing and treatment/injections	 20% 20% 20% 20% 20%
Cardiovascular Disease Screenings Please refer to "Services and Benefits" section of the Plan for additional details and limitations.	0% Deductible waived
Hospital Services **Inpatient Hospital Services** Facility Charges Professional Charges **Emergency Admissions**	 20% 20% Benefits are shown in the Emergency Services Schedule on page 91.
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	20%

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s)unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Laboratory, Diagnostic Therapeutic Radiology and Advanced Imaging Services (Facility and interpretation charges)	
Physician's Office	5%
Free-standing/Independent lab or x-ray facility	5%
Outpatient hospital lab or x-ray	5%
MRIs, MRAs, CAT Scans, PET Scans	20%
Short-Term Rehabilitative Services Physical, Occupational, Chiropractic Therapy	20%
Cardiac & Pulmonary Rehabilitation Maximum of 36 visits per Member, per Calendar Year Limits based on Medical Necessity guidelines	20%
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD) / Orthognathic Surgery	20%
Habilitative Services	20%
Family Planning	
Womens' Contraceptive Services and Sterilization	$0 Deductible waived
Male Sterilization	Copay or Percentage Copayment applies for specific benefit provided
Maternity (Pregnancy and Delivery) /Complications of Pregnancy	
Initial Office Visit to confirm pregnancy and subsequent prenatal visits billed separately from the "global" fee	PCP or Specialist Office visit benefit applies
Prenatal services, Postnatal and Delivery (billed as "global" fee)	20%
Hospital Delivery charges	20%
Prenatal testing or treatment billed separately from "global" fee	20%
Postnatal visit or treatment billed separately from "global" fee	PCP or Specialist Office visit benefit applies

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s)unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Dialysis **Inpatient** **Outpatient**	 Inpatient Hospital Services benefit applies 20%
Autism Spectrum Disorders Diagnosis of Autism Spectrum Disorder Office Visit Diagnostic testing Treatment of Autism Spectrum Disorder Please refer to “Autism Spectrum Disorder” section of the Plan for specific details and limitations.	 PCP or Specialist Office Visit benefit applies 20% Copay or Percentage Copayment applies for specific benefit provided
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 25 days per Member, per Calendar Year for all facilities listed.	 20%
Home Health Services	20%
External Prosthetic Appliances	20%
Durable Medical Equipment	20%
Hospice Inpatient Outpatient	 20% 20%
Newborn/Infant Hearing Screening	0% Deductible waived
Speech and Hearing Restore loss of or correct an impaired speech or hearing function Maximum of 1 hearing aid per ear every 3 years per Member	 20% 20%

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s)unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Mental, Emotional, Functional Nervous Disorders and Serious Mental Illness	
Inpatient (Includes Acute and Residential Treatment)	20%
Outpatient (Includes individual, group, intensive outpatient and partial hospitalization)	
Office Visit	$75 Copayment Deductible waived
All other outpatient services	5%
Substance Use Disorder	
Inpatient Detoxification/Rehabilitation (Includes Acute and Residential Treatment)	20%
Outpatient (Includes individual, group, intensive outpatient and partial hospitalization)	
Office Visit	$75 Copayment Deductible waived
All other outpatient services	5%
Organ and Tissue Transplants- (see benefit detail in "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.)	
Cigna LIFESOURCE Transplant Network® Facility	0%
Other Cigna Network Facility	20%
Out-of-Network Facility	NOT APPLICABLE
Infusion and Injectable Specialty Prescription Medications and related services or supplies	20%

Emergency Services **(Note: This Plan covers Emergency Services from In- and Out-of-Network Providers as shown:**	***What You Pay*** For **Participating Providers** based on the Cigna Contract Allowance	***What You Pay*** For **Non-Participating Providers** based on the Maximum Reimbursable Charge
Emergency Services –		
Hospital Emergency Room	20%	In-network benefit level for an Emergency Medical Condition, otherwise 100%
Urgent Care Services	$75 Copayment per visit Deductible waived	In-network benefit level for an Emergency Medical Condition, otherwise 100%
Ambulance Services Note: coverage for Medically Necessary transport to the nearest facility capable of handling an Emergency Medical Condition.		
Emergency Transport	20%	In-network benefit level for an Emergency Medical Condition, otherwise 100%
Non-Emergency Transport	Not Covered	Not Covered
Inpatient Hospital Services (for emergency admission to an acute care Hospital)		
Hospital Facility Charges	20%	In-Network benefit level until transferable to an In-Network Hospital; if not transferred then Not Covered
Professional Services	20%	In-Network benefit level until transferable to an In-Network Hospital; if not transferred then Not Covered

PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY YOU PAY AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	CIGNA HOME DELIVERY PHARMACY YOU PAY
In the event that You request a "brand-name" drug that has a generic equivalent, You will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the "generic" Copay or Percentage Copayment shown in the Benefit Schedule.		
	Cigna Retail Pharmacy Drug Program YOU PAY PER PRESCRIPTION OR REFILL:	**Cigna Mail Order Pharmacy Drug Program YOU PAY PER PRESCRIPTION OR REFILL:**
Tier 1: Preferred Generic	$4 Copay per Prescription or refill Deductible waived (Up to a 90 day maximum supply. For Copay Plans, You pay a Copay for each 30-day supply)	$10 Copay per Prescription or refill Deductible waived (Up to a 90 day maximum supply)
Tier 2: Non-Preferred Generic	$10 Copay per Prescription or refill Deductible waived (Up to a 90 day maximum supply. For Copay Plans, You pay a Copay for each 30-day supply)	$25 Copay per Prescription or refill Deductible waived (Up to a 90 day maximum supply)
Tier 3: Preferred Brand	$50 Copay per Prescription or refill Deductible waived (Up to a 90 day maximum supply. For Copay Plans, You pay a Copay for each 30-day supply)	$125 Copay per Prescription or refill Deductible waived (Up to a 90 day maximum supply)
Tier 4: Non-Preferred Brand	20% per Prescription or refill (Up to a 90 day maximum supply)	20% per Prescription or refill (Up to a 90 day maximum supply)
Tier 5: Specialty generic and brand name medications that meet the criteria of specialty drugs	$550 Copay per Prescription or refill Deductible waived (Up to a 30 day maximum supply)	$475 Copay per Prescription or refill Deductible waived (Up to a 30 day maximum supply)
Preventive Drugs regardless of Tier Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including women's contraceptives) that are: ▪ Prescribed by a Physician ▪ Generic or Brand Name with no Generic alternative Up to a 90 day maximum supply	0% Deductible waived per Prescription or refill	0% Deductible waived per Prescription or refill