Cigna Health and Life Insurance Company may change the premiums of this Policy after 60 days written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company (“Cigna”)

Cigna Health Flex 6400

If You Wish To Cancel Or If You Have Questions

If You are not satisfied, for any reason, with the terms of this Policy 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 Policy will then be null and void. If You wish to correspond with Us for this or any other 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.

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Policy was issued to You by CIGNA HEALTH AND LIFE INSURANCE COMPANY (referred to herein as Cigna) based on the information You provided in Your application, a copy of which is attached to the Policy. If You know of any misstatement in Your application You should advise the Company immediately regarding the incorrect information; otherwise, Your Policy may not be a valid contract.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY AND WILL NOT DUPLICATE MEDICARE BENEFITS. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM THE COMPANY.

Guaranteed Renewable

This Policy is monthly or quarterly medical coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy. **Coverage under this Policy is effective at 12:01 a.m. Eastern time on the Effective Date shown on the Policy’s specification page.**

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

Signed for Cigna by:

Matthew G. Manders, President

Anna Krishtul, Corporate Secretary

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact your Cigna Health and Life Insurance at:
1-877-484-5962

You may call Cigna Health and Life Insurance Company's toll-free telephone number for information or to make a complaint at
1-877-484-5962

You may also write to Cigna Health and Life Insurance Company at:

Cigna Health and Life Insurance Company
P. O. 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

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

PREMIUM OR CLAIM DISPUTES:
Should You have a dispute concerning Your premium or about a claim, You should contact Cigna first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para presentar una queja:

Usted pude comunicarse con su Cigna Health and Life Insurance al:
1-877-484-5962

Usted puede llamar al numero de telefono gratuito de Cigna Health and Life Insurance Company para obtener informacion o para presentar una queja al
1-877-484-5962

Usted tambien puede escribir a Cigna Health and Life Insurance Company:

Cigna Health and Life Insurance Company
P. O. Box 30365
Tampa, FL 33630-3365

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener informacion sobre companias, coberturas, derechos, o quejas al:

1-800-252-3439

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

DISPUTAS POR PRIMAS DE SEGUROS O RECLOMAIONES:
Si tiene una disputa relacionada con su prima de seguro o con una reclamacion, usted debe comunicarse con Cigna primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

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.

IMPORTANT NOTICE

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, 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

You have the option to designate a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For 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 provider.

NOTICE OF RIGHTS UNDER A NETWORK PLAN (PPO)

You have the right to an adequate network of preferred providers (also known as network providers).

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
- If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your In-Network deductible and Out-of-Pocket Maximum.

You have the right, in most cases, to obtain estimates in advance:

- from Out-of-Network Providers of what they will charge for their services; and
- from your insurer of what they will pay for the services.

You may obtain a current directory of preferred providers at the following website: www.cigna.com/cignastatedirectory/cigna-in-texas or by calling the toll free number on the back of your ID card for assistance in finding available preferred providers.

- If the directory is materially inaccurate, you may be entitled to have an out-of network claim paid at the in-network level of benefits.
- If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.
- If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.

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Introduction

About This Policy

Your medical coverage is provided under a Policy issued by CIGNA HEALTH AND LIFE INSURANCE COMPANY ("Cigna") This Policy is a legal contract between You and Us.

Under this Policy, "We", "Us", and "Our" mean Cigna. "You" or "Your" refers to the Policyholder whose application has been accepted by Us under the Policy issued. When We use the term "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(s) covered under this Policy are listed on the Policy specification page.

The benefits of this Policy are provided only for those services that are Medically Necessary as defined in this Policy and for which the Insured Person 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 Policy or phone Us at the number shown on Your Cigna identification card if You have any questions regarding whether services are covered.

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

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

IF, WITHIN 2 YEARS AFTER THE EFFECTIVE DATE OF YOUR PARTICIPATION IN THE POLICY, WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED OR THAT YOU OR YOUR FAMILY MEMBER (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 FAMILY MEMBER(S) (EXCLUDING NEWBORN CHILDREN OF THE INSURED ADDED WITHIN 31 DAYS AFTER BIRTH), WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED OR THAT YOU OR YOUR FAMILY MEMBER (S) KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND COVERAGE FOR THE ADDITIONAL FAMILY MEMBER (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 POLICY 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 EXCEED TOTAL PREMIUMS 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 NEGOTIATED RATE.

About Your Cigna Plan

Under Texas statutes, "Preferred provider benefit plan" means a benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider.

Your Cigna Open Access Plan is a preferred provider benefit plan with certain managed care features. This Plan allows You "open access" to select any Physician, Hospital or other Provider, regardless of whether that Provider is in the Plan's network or not. However, the Plan has a different level of benefits for In-Network Providers than for Out-of-Network Providers. Your cost share for Covered Services will be higher when you use Out-of-Network Providers. This Plan also gives You the opportunity to designate a Primary Care Physician (PCP) if You wish. You are not required to designate a PCP; benefit levels are determined by whether a Provider is in the Plan network or not.

CHOICE OF HOSPITAL AND PHYSICIAN: Nothing contained in this Policy restricts or interferes with an Insured Person's right to select the Hospital or Physician of their choice. You may pay more for Covered Services, however, if the Insured Person receives them from a Hospital or Physician that is a Non-Participating Provider.

Note Regarding Health Savings Accounts (HSAs)

Cigna offers some plans that are intended to qualify as "high deductible health plans" (as defined in 26 U.S.C. § 223(c)(2)). Plans that qualify as high deductible health plans may allow You, if You are an "eligible individual" (as defined in 26 U.S.C. § 223(c)(1)), to take advantage of the income tax benefits available when You establish an HSA and use the money You deposit into the HSA to pay for qualified medical expenses as allowed under federal tax law.

Cigna does not provide tax advice. **It is Your responsibility to consult with Your tax advisor or attorney about whether a plan qualifies as a high deductible health plan and whether You are eligible to take advantage of HSA tax benefits.**

Prior Authorization Program

Cigna provides You with a comprehensive personal health solution medical management program which focuses on improving quality outcomes and maximizes value for You.

PRIOR AUTHORIZATION FOR INPATIENT SERVICES
Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION TO A HOSPITAL OR CERTAIN OTHER FACILITIES MAY RESULT IN A PENALTY.

Prior Authorization can be obtained by You, Your Family Member(s) or the Provider by calling the number on the back of Your ID card.

To verify Prior Authorization requirements for inpatient services including, which other types of facility admissions require Prior Authorization, You can:

- Call Cigna at the number on the back of your ID card, or
- Check mycigna.com, under "View Medical Benefit Details"

Please note that emergency admissions will be reviewed post admission.

Inpatient Prior Authorization reviews both the necessity for the admission and the need for continued stay in the hospital.

PRIOR AUTHORIZATION OF OUTPATIENT SERVICES

Prior Authorization is also required for certain outpatient procedures and services in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO CERTAIN ELECTIVE OUTPATIENT PROCEDURES AND SERVICES MAY RESULT IN A PENALTY.

Prior Authorization can be obtained by You, Your Family Member(s) or the Provider by calling the number on the back of Your ID card. Outpatient Prior Authorization should only be requested for non-emergency procedures or services, at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

To verify Prior Authorization requirements for outpatient procedures and services, including which procedures and services require Prior Authorization, You can:

- Call Cigna at the number on the back of your ID card, or
- Check mycigna.com, under "View Medical Benefit Details"

PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. Regardless of Prior Authorization, coverage is always subject to other requirements of this Policy limitations and exclusions, payment of premium and eligibility at the time care and services are provided. However, once You have received Prior Authorization of medical care or health care services, Cigna may not deny or reduce payment for those services based on medical necessity or appropriateness of care unless the Provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the proposed medical or health care services.

Retrospective Review

If Prior Authorization was not performed Cigna will use retrospective review to determine if a scheduled or Emergency admission was Medically Necessary. In the event the services are determined to be Medically Necessary, benefits will be provided as described in this Policy. If it is determined that a service was not Medically Necessary, the Insured Person is responsible for payment of the charges for those services.

Prior Authorization—Prescription Drugs

Coverage for certain Prescription Drugs and Related Supplies require 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 Physician 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 Insured Person has previously used an alternative non-restricted access drug or device and the alternative drug or device has been detrimental to the Insured Person'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 Insured Person's health or ineffective in treating the condition again. The Physician should make this request before writing the prescription.

BENEFIT SCHEDULE

Following is the Benefit Schedule, including medical, prescription drugs and pediatric vision benefits. The Policy 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 Insured Person's **READ THE ENTIRE POLICY CAREFULLY!**

The benefits outlined in the table below show the payment for Covered Expenses.

NOTE: Amounts shown below are Your responsibility after any applicable Deductible has been met, unless otherwise indicated. Copayment amounts shown are also Your responsibility.

BENEFIT INFORMATION **Note:** **Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.**	**IN-NETWORK – YOU PAY (Based on Negotiated Rate)** **AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY**	**OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)**
Medical Benefits		
Annual Plan Deductible *Individual* *Family*	**In-Network Deductible** $6,400 $12,800	**Out-of-Network Deductible** $12,500 $25,000
Out-of-Pocket Maximum *Individual* *Family*	**In-Network Out-of-Pocket Maximum** $6,700 $13,400 The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties and Policy Maximums.	**Out-of-Network Out-of-Pocket Maximum** $25,000 $50,000 The following do not accumulate to the Out-of-Network Out of Pocket Maximum: Penalties and Policy Maximums.
Coinsurance	You and Your Family Members pay 40% of Charges after the plan Deductible.	You and Your Family Members pay 50% after the plan Deductible.
Prior Authorization Program **Prior Authorization – Inpatient Services**	Your Provider must obtain approval for inpatient admissions; or Your Provider may be assessed a penalty for non-compliance.	You and Your Family Member(s) must obtain approval for inpatient admission; or Your benefits may be reduced by the lesser of 50% or a $500, 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. 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 Provider must obtain approval for certain outpatient procedures and services; or Your Provider may be assessed a penalty for non-compliance.	You and Your Family Member(s) must obtain approval for certain outpatient procedures and services; or Your benefits may be reduced by the lesser of 50% or $60, penalty for non-compliance.

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.	IN-NETWORK – YOU PAY (Based on Negotiated Rate)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	
All Preventive Well Care Services Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details	0% Deductible waived	50%
Immunizations	0% Deductible waived	0% Deductible waived
Pediatric Vision Care Performed by an Ophthalmologist, Optometrist or Therapeutic Optometrist for an Insured Person 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	You pay all except $45
Pediatric Frames for Children Limited to one pair per year	0% Deductible waived	You pay all except $30 for frames
Eyeglass Lenses for Children Single Vision, Lined Bifocal, Lined Trifocal Lenticular Limited to one pair per year	0% Deductible waived	You pay all except $32 You pay all except $55 You pay all except $65 You pay all except $80
Contact Lenses and Professional Services for Children (Limited to one pair per year)		
Elective	0% Deductible waived	You pay all except $87
Therapeutic	0% Deductible waived	You pay all except $250
Note: Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit		

BENEFIT INFORMATION **Note:** **Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.**	IN-NETWORK – YOU PAY (Based on Negotiated Rate)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	
Physician Services **Office Visit**		
RPO – designated PCP	$40 Copayment Deductible waived	50%
RPO- designated Specialist	$70 Copayment Deductible waived	50%
Primary Care Physician (PCP)	40%	50%
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*	40%	50%
Physician Services, continued Surgery in Physician's office	40%	50%
Outpatient Professional Fees for Surgery *(including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy)*	40%	50%
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	40%	50%
In-hospital visits	40%	50%
Allergy testing and treatment/injections	40%	50%
Cardiovascular Disease Screenings Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details and limitations.	0% Deductible waived	0% Deductible waived

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.	IN-NETWORK – YOU PAY (Based on Negotiated Rate)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	
Hospital Services **Inpatient Hospital Services**		
Facility Charges	40%	50%
Professional Charges	40%	50%
Emergency Admissions		
Facility Charges	40%	In-Network benefit level until transferable to an In-Network Hospital then 50%
Professional Charges	40%	In-Network benefit level until transferable to an In-Network Hospital then 50%%
Outpatient Facility Services *Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities*	40%	50%
Emergency Services *(Emergency Services are available 24/7)*		
Emergency Room	40%	In-network benefit level for an Emergency Medical Condition, otherwise 50%
Ambulance (emergency transportation to the nearest facility capable of handling the emergency only.)	40%	In-network benefit level for an Emergency Medical Condition, otherwise 50%
Urgent Care	$75 Copayment per Deductible waived	In-network benefit level for an Emergency Medical Condition, otherwise 50%
Advanced Radiological Imaging (including MRIs, MRAs, CAT Scans, PET Scans) Facility and interpretation charges	40%	50%
All Other Laboratory and Radiology Services Facility and interpretation charges		
Physician's Office	40%	50%
Free-standing/Independent lab or x-ray facility	40%	50%
Outpatient hospital lab or x-ray	40%	50%

BENEFIT INFORMATION **Note:** **Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.**	**IN-NETWORK – YOU PAY (Based on Negotiated Rate)**	**OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)**
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	
Short-Term Rehabilitative Services *Physical, Occupational, Chiropractic Therapy* Maximum of 35 visits per Insured Person, per Calendar Year for all therapies In- and Out-of-Network combined. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders	40%	50%
Cardiac & Pulmonary Rehabilitation Maximum of 36 visits per Insured Person, per Calendar Year, In- and Out-of-Network combined. Limits based on Medical Necessity guidelines	40%	50%
Treatment of Temporomandibular Joint Dysfunction / Orthognathic Surgery (TMJ/TMD)	40%	50%
Habilitative Services Maximum of 35 visits per Insured Person, per calendar year for all therapies, In- and Out-of-Network combined. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders	40%	50%
Womens' Contraceptive Services, Family Planning and Sterilization	$0 Deductible waived	50%
Male Sterilization	Copay or Coinsurance applies for specific benefit provided	50%

BENEFIT INFORMATION **Note:** **Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.**	**IN-NETWORK – YOU PAY (Based on Negotiated Rate)**	**OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)**
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	
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	50%
Prenatal services, Postnatal and Delivery (billed as "global" fee)	40%	50%
Hospital Delivery charges	40%	50%
Prenatal testing or treatment billed separately from "global" fee	40%	50%
Postnatal visit or treatment billed separately from "global" fee	PCP or Specialist Office Visit benefit applies	50%
Dialysis		
Inpatient	Inpatient Hospital Services benefit applies	50%
Outpatient	40%	50%
Autism Spectrum Disorders		
Diagnosis of Autism Spectrum Disorder		
Office Visit	PCP or Specialist Office Visit benefit applies	50%
Diagnostic testing	40%	50%
Treatment of Autism Spectrum Disorder *(see "Comprehensive Benefits: What the Policy Pays For" section for specific information about what services are covered)*	Copay or Coinsurance applies for specific benefit provided	50%

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.	IN-NETWORK – YOU PAY (Based on Negotiated Rate)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 25 days per Insured Person, per Calendar Year combined In- and Out-of-Network for all facilities listed.	40%	50%
Home Health Services Maximum 60 visits per Insured Person, per Calendar Year combined In- and Out-of-Network. Maximum 16 hours per day. Maximum 4 visits per day.	40%	50%
External Prosthetic Appliances	40%	50%
Durable Medical Equipment	40%	50%
Hospice		
Inpatient	40%	50%
Outpatient	40%	50%
Newborn/Infant Hearing Screening	0% Deductible waived	40% Deductible waived
Speech and Hearing Restore loss of or correct an impaired speech or hearing function	40%	50%
Maximum of 1 hearing aid per ear every 3 years per Insured Person	40%	50%

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.	IN-NETWORK – YOU PAY (Based on Negotiated Rate)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	
Mental, Emotional, Functional Nervous Disorders and Serious Mental Illness		
Inpatient *(Includes Acute and Residential Treatment)*	40%	50%
Outpatient *(Includes individual, group, intensive outpatient and partial hospitalization)*		
Office Visit	40%	50%
All other outpatient services	40%	50%
Substance Use Disorder		
Inpatient Detoxification/Rehabilitation *(Includes Acute and Residential Treatment)*	40%	50%
Outpatient *(Includes individual, group, intensive outpatient and partial hospitalization)*		
Office Visit	40%	50%
All other outpatient services	40%	50%
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%	NOT APPLICABLE
Other Cigna Network Facility	40%	NOT APPLICABLE
Out-of-Network Facility	NOT APPLICABLE	50%
Infusion and Injectable Specialty Prescription Medications and related services or supplies	40%	50%

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.	IN-NETWORK – YOU PAY (Based on Negotiated Rate)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	
Dental Care Limited to treatment for accidental injury to natural teeth within twenty-four months of the accidental injury	40%	50%

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Negotiated Rate)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
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 Coinsurance shown in the Benefit Schedule.		
Cigna Retail Pharmacy Drug Program		
Tier 1: Retail Preferred Generic Up to a 90 day maximum supply. For Copay Plans, You pay a Copay for each 30-day supply.	$8 Copay per Prescription or refill Deductible waived	50% per Prescription or refill
Tier 2: Retail Non-Preferred Generic Up to a 90 day maximum supply. For Copay Plans, You pay a Copay for each 30-day supply.	$40 Copay per Prescription or refill Deductible waived	50% per Prescription or refill
Tier 3: Retail Preferred Brand Up to a 90 day maximum supply.	40% per Prescription or refill	50% per Prescription or refill
Tier 4: Retail Non-Preferred Brand Up to a 90 day maximum supply.	50% per Prescription or refill	50% per Prescription or refill
Tier 5: Retail Specialty generic and brand name medications that meet the criteria of specialty drugs Up to a 30 day maximum supply,	$550 Copay per Prescription or refill	50% per Prescription or refill
Retail Pharmacy Preventive Drugs regardless of Tier Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' 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	50% per Prescription or refill

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Negotiated Rate)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Cigna Mail Order Pharmacy Drug Program		
Tier 1: Mail Order Preferred Generic Up to a 90 day maximum supply	$20 Copay per Prescription or refill Deductible waived	50% per Prescription or refill
Tier 2: Mail Order Non-Preferred Generic Up to a 90 day maximum supply	$100 Copay per Prescription or refill Deductible waived	50% per Prescription or refill
Tier 3: Mail Order Preferred Brand Up to a 90 day maximum supply	40% per Prescription or refill	50% per Prescription or refill
Tier 4: Mail Order Non-Preferred Brand Up to a 90 day maximum supply	50% per Prescription or refill	50% per Prescription or refill
Tier 5: Mail Order Specialty generic and brand name medications that meet the criteria of specialty drugs Up to a 30 day maximum supply	$475 Copay per Prescription or refill Deductible waived	50% per Prescription or refill
Mail Order Pharmacy Preventive Drugs regardless of Tier Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' 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	50% per Prescription or refill

Benefit Schedule Form Number : INDTXPPOBNFTSCH042015

Definitions

The following definitions contain the meanings of key terms used in this Policy. Throughout this Policy, the terms defined appear with the first letter of each word in capital letters.

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 Insured Person 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.

Annual, Calendar Year, Year is a 12-month period beginning each January 1 at 12:01 a.m. Eastern Time.

Annual Open Enrollment Period means the designated period of time during each Calendar Year when individuals can apply for coverage under this Policy 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 a neurobiological disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder--not otherwise specified. A "Neurobiological disorder" means an Illness of the nervous system caused by genetic, metabolic, or other biological factors.

Brand Name Prescription Drug (Brand Name) means ~~is~~ a Prescription Drug that has been patented and is only produced by one manufacturer.

Cigna We, Our, and Us mean Cigna (Cigna Health and Life Insurance Company), or an affiliate. Cigna is a licensed and regulated insurance company operating throughout the United States.

Coinsurance means the percentage of Covered Expenses the Insured Person is responsible for paying after applicable Deductibles are satisfied). **Coinsurance does not include Copayments. Coinsurance 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 Policy.**

Copayment/Copay is a set dollar amount of Covered Expenses the Insured Person is responsible for paying. Copayment does not include charges for services that are not Covered Services or charges in excess of Covered Expenses. Copayments are calculated separately from Coinsurance.

Cosmetic Surgery 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 are the expenses incurred for Covered Services under this Policy for which Cigna will consider for payment under this Policy. Covered Expenses will never exceed the Negotiated Rate for Participating Providers nor will they exceed Maximum Reimbursable Charges for Non-Participating Providers. In addition, Covered Expenses may be limited by other specific maximums described in this Policy. Covered Expenses are subject to applicable Deductibles and other benefit limits. **An expense is incurred on the date the Insured Person receives the service or supply.** Covered Expenses may be less than the amount that is actually billed.

Covered Services are Medically Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

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

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

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy. Several types of Deductibles may apply to this Policy and all are defined in this section. See the definitions for Additional Deductible, Individual In-Network Deductible, Family In-Network Deductible, Individual Out-of-Network Deductible, Family Out-of-Network Deductible.

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

Diabetes Equipment includes, but is not limited to, blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by blind persons; insulin pumps and associated appurtenances; to include 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 including up to two pair of therapeutic footwear per year, 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 is instruction which enables a diabetic patient and his or her caretaker to understand the diabetic care and management process, including nutritional counseling and proper use of equipment and supplies and daily management of diabetic therapy as means of avoiding frequent hospitalization and complications.

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

Diabetes New or Improved Equipment or Supplies including 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.

Effective Date is the date on which coverage under this Policy begins for You and any of Your Family Member(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;
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: To the extent covered under this plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Experimental / Investigational Procedures: 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 it 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 In-Network Deductible applies if You cover other Family Member(s). Each Insured Person can contribute up to the Individual In-Network Deductible amount toward the Family In-Network Deductible. The Individual In-Network Deductible paid by each Family Member counts towards satisfying the Family In-Network Deductible. Once the Family In-Network Deductible amount is satisfied, the remaining Individual In-Network Deductibles will be waived for the remainder of the Year. The amount of the Family In-Network Deductible is described in the Schedule of Benefits section of this Policy.

Family In-Network Out-of-Pocket Maximum: applies if You cover other Family Member(s). Each Insured Person can contribute up to the Individual In-Network Out-of-Pocket amount toward the Family In-Network Out-of-Pocket maximum. Once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Family In-Network Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an

accumulation of Covered Expenses incurred from Participating Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Network Deductible applies if You cover other Family Member(s). Each Insured Person can contribute up to the Individual Out-of-Network Deductible amount toward the Family Out-of-Network Deductible. The Individual Out-of-Network Deductible paid by each Family Member counts towards satisfying the Family Out-of-Network Deductible. Once the Family Out-of-Network Deductible amount is satisfied, the remaining Individual Out-of-Network Deductibles will be waived for the remainder of the Year. The amount of the Family Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy.

Family Out-of-Network Out-of-Pocket Maximum: applies if You cover other Family Member(s). Each Insured Person can contribute up to the Individual Out-of-Network Out-of-Pocket amount toward the Family Out-of-Network Out-of-Pocket maximum. Once the Family Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Family Out-of-Network Out of Pocket Maximum and will always be paid by You. The Family Out-of-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. The amount of the Family Out-of-Network Out of Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Free-Standing Outpatient Surgical Facility
The term 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.

Habilitative Services are those services that are

(i) 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,

(ii) are expected to result in significant and measurable therapeutic or developmental improvement over a clearly defined period of time, and

(iii) are individualized and there is documentation outlining quantifiable, measurable and attainable treatment goals.

Home Health Agencies and Visiting Nurse Associations are 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; 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 Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Agency and Visiting Nurse Associations (d) a hospice facility, or (e) any other licensed facility or agency under a hospice care program.

Hospital is 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.

Individual In-Network Deductible is 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 In-Network Deductible is described in the Schedule of Benefits section of this Policy.

Individual In-Network Out-of-Pocket Maximum: Once the Individual In-Network Out-of-Pocket Maximum has been met for the Year, for Covered Services received from Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Individual In-Network Out-of-Pocket Maximum and will always be paid by You. The Individual In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Coinsurance for medical services incurred from Participating Providers. The amount of the Individual In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Individual Out-of-Network Out of Pocket Maximum: Once the Individual Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Individual Out-of-Network Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. The amount of the Individual Out-of-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Illness is a sickness, disease, or condition of an Insured Person.

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 Prior Authorization or pre-certification.

Injury means an accidental bodily injury.

In-Network Out of Pocket Maximum is the maximum amount of Deductible, Copayment and Coinsurance each Individual or Family incurs in Covered Expenses from Participating Providers in a Year.

Insured/Policyholder means the applicant who has applied for, been accepted for coverage, and who is names as the Insured on the specification page.

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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
- The usual, reasonable and customary charges made by providers of such service or supply in the geographic area where it is received, as compiled in a nationally-recognized database that uses generally accepted industry standards and practices for determining the customary and reasonable billed charges for a service, and that fairly and accurately reflects market rate; or.
- A percentage of a fee schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market. **This methodology is not applied for services listed under the Specific Circumstances section of Your Policy; or**
- The median amount negotiated with In-Network Cigna providers for the same services. **This methodology is not applied for services listed under the Specific Circumstances section of Your Policy.**

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

Medically Necessary services or supplies are those that Cigna determines 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.
- Within generally accepted standards of good medical practice within the community or qualified professionals.
- Not primarily for the convenience of any Insured Person, Physician, or another Provider's.
- 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 the beneficial health outcomes; demonstrating that the expected health benefits are clinically significant and produce 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 of Confinement does not in and of itself make it Medically Necessary or a Medical Necessity.

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

Mental, Emotional or Functional Nervous Disorders are neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Negotiated Rate is the rate of payment that has been negotiated with a Participating Provider for Covered Services.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on Maximum Reimbursable Charges which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

Office Visit means a visit by the Insured Person, 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.

Orthoses and Orthotic Devices are 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.

Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing facilities, rehabilitation Hospitals and sub-acute facilities.

Out-of-Network Out of Pocket Maximum is the maximum amount of Deductible, Copayment and Coinsurance each Individual or Family incurs in Covered Expenses from Non-Participating Providers in a Year.

Participating Pharmacy is a retail Pharmacy with which Cigna has contracted to provide prescription services to Insured Persons; or a designated mail-order Pharmacy with which Cigna has contracted to provide mail-order prescription services to Insured Persons.

Participating Provider is a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services with regard to a particular Policy under which an Insured Person is covered. A Participating Provider may also be referred to in this Policy by type of Provider—for example, a Participating Hospital or Participating Physician.

Patient Protection and Affordable Care Act of 2010 (PPACA)
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 Policy provided to an Insured Person who is under age 19.

Physical and/or Occupational Therapy/Medicine is 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.

Pharmacy is a retail Pharmacy, or a mail-order Pharmacy.

Pharmacy & Therapeutics (P & T) Committee is 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 is a Physician licensed to practice medicine or any other practitioner who is licensed and recognized as a provider of health care services and provides services covered by the Policy that are within the scope of his or her licensure.

Policy is the set of benefits, conditions, exclusions, limitations, and premiums described in this document, including the Policy specification page, the benefit schedule, the completed and accepted application for coverage attached to this Policy, and any amendments or endorsements to this document.

Policy Year is defined as a 12-month period that begins each January 1.

Note: Deductible and other benefit accumulations accumulate on a Calendar Year rather than Policy Year basis.

Prescription Drug is

- 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 is 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 is the 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.

Primary Care Physician is a Physician:

- who is a general practitioner, internist, family practitioner or pediatrician; and
- who has been selected by the Insured Person to provide or arrange for medical care for the Insured Person.

Prior Authorization: Inpatient Hospital admissions and certain services, equipment and other facility admissions require authorization in advance by Cigna to be eligible for benefits. If You, Your Family Member or the Provider fail to obtain Prior Authorization when required to do so by this Policy, We may apply a penalty that will reduce Covered Expenses for the unauthorized services. Please call Cigna at the number on Your ID card to assure that all Prior Authorization requirements are met.

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

Prostheses/Prosthetic Appliances and Devices
Prostheses/prosthetic appliances and devices are defined as artificial devices designed to replace wholly or partly, an arm or leg. Prostheses/prosthetic appliances and devices include, but are not limited to:

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

Provider means a Hospital, a Physician or any other health care practitioner acting within the scope of the practitioner's license.

Reconstructive Surgery is 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 Policy, breast reconstruction means reconstruction of a breast incident to mastectomy or lumpectomy 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.

Reconstructive Surgery for Craniofacial Abnormalities for Children 18 Years of Age or Younger
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.

Related Supplies are diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for self- injectable 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, diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills); disposable needles and syringes needed for injecting covered drugs and supplements.

Self-administered Injectable Drugs are 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.

Skilled Nursing Facility is an institution that provides continuous skilled nursing services. It must:

- be an institution licensed and operated pursuant to law, and
- be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician, and

- provide continuous 24 hours a 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 are special areas of a Hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Special Limits are limits applied to certain Covered Expenses in the form of per visit, per day, or per event maximum. We will only apply the Special Limit amount to any Deductible. Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits to the applicable Covered Expenses. The expenses you incur which exceed specific maximums described in this Policy will be Your responsibility. The Special Limits are described in the Benefit Schedule and in the section of this Policy titled "How The Policy Works".

Specialty Medication means medications which are used to treat an underlying disease which is considered to be rare and chronic conditions, including, but 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.

Telemedicine/Telehealth as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. "Telemedicine" does not include the use of audio-only telephone, facsimile machine or e-mail.

Terminal Illness is an Illness due to which a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

You, Your, and Yourself is the Policyholder who has applied for, and been accepted for coverage, as an Insured under the Policy and is named as the Insured on the specification page.

Who Is Eligible For Coverage?

Eligibility Requirements

This Policy is for residents of the state of Texas. The Policyholder must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy if, at the time of application:

- You are 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; and
- You are a resident of the state of Texas; and
- You are not incarcerated other than incarceration pending the disposition of charges
- You live within the Service Area of this Policy; and
- You have submitted a completed and signed application for coverage and have been accepted in writing by Us.

Other Insured Persons may include the following Family Members:

- Your lawful spouse.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your grandchildren who have not yet reached age 26 if they are Your dependents for Federal Income Tax purposes at the time of application.
- Your own or Your spouse's children, regardless of age, who are incapable of self-support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Insured 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.
- Your own or Your 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 an Insured Family 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.
- Your Newborn grandchild will be automatically covered for the first 31 days of life if this grandchild is Your dependent for Federal Income Tax purposes at the time of application. To continue coverage past that time You must enroll the grandchild as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date You acquire the grandchild as a dependent, and pay any additional premium. Coverage for an eligible grandchild enrolled within 61 days of the court order will be retroactive to the date of the court order.
- 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 an Insured Family 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 an Insured 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 an Insured Family 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.

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 an Insured Person can add dependents and change coverage.

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

Annual Open Enrollment Period

The Annual 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 Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period.

Your coverage under this Policy will then become effective upon 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; or
- 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; or
- An eligible individual gaining or becoming a dependent through marriage, birth adoption; or placement for adoption; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is 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 demonstrates 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 gains 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
- An 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, or
- An eligible individual or enrollee demonstrates to the 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; and 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, an Insured Person will become ineligible for coverage under the Policy:

- When premiums are not paid according to the due dates and grace periods described in the premium section.
- For the spouse - when the spouse is no longer married to the Insured.
- For You and Your Family Member(s) - when the Insured Person no longer meets the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person's eligibility under this Policy would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured'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 Policy would otherwise terminate. In such a case, coverage will continue without evidence of insurability.

How The Policy Works

This section describes Deductibles and Copayments/Coinsurance, and discusses steps the Insured Person should take to ensure that they receive the highest level of benefits available under this Policy. Please refer to the "Definitions" section of the Policy to understand the meaning of Covered Expenses and Covered Services.

The benefits described in the following sections are provided for Covered Expenses incurred while covered under this Policy. An expense is incurred on the date the Insured Person receives the service or supply for which the charge is made. These benefits are subject to all provisions of this Policy, some of which may limit benefits or result in benefits not being payable.

Either the Insured Person or the provider of service must claim benefits by sending Us properly completed claim forms itemizing the services or supplies received and the charges. See "General Provisions", "How to File a Claim for Benefits", for further information.

Benefit Schedule

The Benefit Schedule shows the maximum Covered Expense for each type of benefit.

No benefits are payable unless the Insured Person's coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms, conditions, limitations and exclusions of this Policy.

Participating Hospitals, Participating Physicians and Other Participating Providers.

Covered Expenses for Participating Providers are based on Our Negotiated Rate. Participating Providers have agreed **NOT** to charge more than the Cigna Negotiated Rates for Covered Services. Participating Providers may charge the Insured Person for services that are not Covered Services under the Policy. In addition, Participating Providers will file claims with Us for the Insured Person, and will request Prior Authorization when it is required.

Be sure to check with the provider prior to an appointment to verify that the provider is currently contracted with Cigna.

Non-Participating Hospitals, Non-Participating Physicians, and Other Non-Participating Providers.

Covered Expenses for services provided by a Non-Participating Provider will not exceed the lesser of actual billed charges, or a Maximum Reimbursable Charge. These services may be subject to additional Deductibles.

Specific Circumstances

Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule and the allowable amount will be calculated based on Maximum Reimbursable Charges in certain circumstances as provided below:

- **Hospital Emergency Services**
  Emergency Services for an Emergency Medical Condition will be paid at the Participating Provider benefit schedule and the allowable amount will be calculated based on Maximum Reimbursable Charges. Once the patient is stabilized and he/she can reasonably be transferred, to a Participating Hospital, medical payment will be reduced to the Non-Participating Provider benefit schedule if the Insured Person is not transferred to a Participating Hospital as soon as his or her medical condition permits.

- **Physician or other provider Emergency Services**
  Covered Expense will be paid at the Participating Provider benefit schedule and the allowable amount will be calculated based on Maximum Reimbursable Charges for the initial care of an Emergency Medical Condition.

- **Availability of Preferred Providers**
  Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule and the allowable amount will be calculated based on Maximum Reimbursable Charges when the services of a Participating Provider are unavailable within the Service Area. Refer to the 'Definitions' section of this Policy for a description of the Service Area.

For more detailed information, visit www.Cigna.com/ifp-providers or www.cigna.com/cignastatedirectory/cigna-in-texas or call 1.800.Cigna.24.

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before benefits are available. Deductibles apply to all Covered Expenses as described in the Definitions section of this Policy, unless expressly stated otherwise in the Benefit Schedule. Deductibles do not include any amounts in excess of Maximum Reimbursable Charges, any penalties, or expenses incurred in addition to Covered Expenses. Any expenses incurred in addition to Covered Expenses are never applied to any Deductible.

Deductibles will be applied in the order in which an Insured Persons claims are received and processed by Us, not necessarily in the order in which the Insured Person received the service or supply.

In-Network Deductible

The In-Network Deductible is stated in the Benefit Schedule. The Deductible is the amount of Covered Expenses You must pay for **any** Covered Services (except as specifically stated otherwise in the Benefit Schedule) incurred from Participating Providers each Year before any benefits are available.

- If You cover other Family Members, the Family In-Network Deductible will apply. Each Insured Person can contribute up to the Individual In-Network Deductible amount toward the Family In-Network Deductible. Once this Family In-Network Deductible is satisfied, no further Family In-Network Deductible is required for the remainder of that Year.

Out-of-Network Deductible

The Out-of-Network Deductible is applied only to Covered Expenses incurred for services received from Non-Participating Providers. Only Maximum Reimbursable Charges will be applied to the Out-of-Network Deductible. Please see Policy Details for how Maximum Reimbursable Charges are calculated.

- The Out-of-Network Deductible is stated in the Benefit Schedule. The Out-of-Network Deductible is the amount of Covered Expenses You must pay for **any** Covered Services (except as specifically stated otherwise in the Benefit Schedule) incurred from Non-Participating Providers each Year before any benefits are available.
- If You cover other Family Members, the Family Out-of-Network Deductible will apply. Each Insured Person can contribute up to the Individual Out-of-Network Deductible amount toward the Family Out-of-Network Deductible. Once this Family Out-of-Network Deductible is satisfied, no further Family Out-of-Network Deductible is required for the remainder of that Year.

Out of Pocket Maximums

The Out of Pocket Maximums are the amount of Coinsurance, Deductible, and Copayment each Insured Person incurs for Covered Expenses in a Year. The Out of Pocket Maximums **do not** include any amounts in excess of Maximum Reimbursable Charges, any penalties, or any amounts in excess of other benefit limits of this Policy.

- Once an Insured Person reaches the Out of Pocket Maximum for either Participating or Non-Participating Providers, in a Calendar Year, the Insured Person will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.
- If you cover other Family Members, the Family Out of Pocket Maximum will apply. Each Insured Person can contribute up to the Individual Out-of-Pocket amount for either In or Out-of-Network Providers toward the Family Out-of-Pocket Maximum for either In- or Out-of-Network Providers. The Out of Pocket Maximum is an accumulation of Covered Services for all Insured Persons for either Participating or Non-Participating Providers in a Year. Once the Out of Pocket has been met the Family will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.

Special Limits

We will only apply the Special amount to any Deductible, even when an Out of Pocket Maximum is reached, We will still apply the Special Limits on certain Covered Expenses described in the Benefit Schedule. Please see the Benefit Schedule for details on Annual or Lifetime payment Maximums which may apply to these specific Benefits.

The expenses you incur which exceed specific maximums described in this Policy will be Your responsibility.

Penalties

A Penalty is an amount of Covered Expenses that is:

- Not counted toward any Deductible;
- Not counted toward the Out of Pocket Maximums;
- Not eligible for benefit payment once the Deductible is satisfied.

If the Insured Person submits a claim for services which have a maximum payment limit, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward Your penalty amount.

Penalties will apply under the following circumstances:

- Inpatient Hospital admissions may be subject to a Penalty if You or Your Provider fail to obtain Prior Authorization.
- Free Standing Outpatient Surgical Facility Services may be subject to a Penalty per admission, if You or Your Provider fail to obtain Prior Authorization.
- Certain outpatient surgeries and diagnostic procedures require Prior Authorization. If You or Your Provider fail to obtain Prior Authorization for such an outpatient surgery or diagnostic procedure, You or Your Provider may be responsible for a Penalty, per admission or per procedure.
- Authorization is required prior to certain other admissions and prior to receiving certain other services and procedures. Failure to obtain Authorization prior these admissions or to receiving these services or procedures may result in a Penalty.

The Insured Person must satisfy any applicable penalty before benefits are available.

Comprehensive Benefits: What the Policy Pays For

Please refer to the Benefit Schedule for additional benefit provisions which may apply to the information below.

Before this Participating Provider Policy pays for any benefits, You and Your Family Members must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

The benefits described in this section will be paid for Covered Expenses incurred on the date You and Your Family Members receive the service or supply for which the charge is made. These benefits are subject to all terms, conditions, Deductibles, penalties, exclusions and limitations of this Policy. All services will be paid at the percentages indicated in the Schedule of Benefits and subject to limits outlined in the section entitled "How the Policy Works".

Following is a general description of the supplies and services for which the Participating Provider Policy will pay benefits if such services and supplies are Medically Necessary and for which You are otherwise eligible as described in this Policy.

Services and Supplies Provided by a Hospital or Free-Standing Outpatient Surgical Facility

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)
For any eligible condition, this Policy provides indicated benefits on Covered Expenses for:

- Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
- Outpatient services and supplies including those in connection with Emergency Services, outpatient surgery and outpatient surgery performed at a Free-Standing Outpatient Surgical Facility.
- Diagnostic/Therapeutic Lab and X-rays.
- Anesthesia and Inhalation Therapy.

Payments of Inpatient Covered Expenses are subject to these conditions:

- Services must be those which are regularly provided and billed by the Hospital or Free-Standing Outpatient Surgical Facility.
- Services are provided only for the number of days required to treat the Insured Person's Illness or Injury.

Note: No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Services and Supplies Provided by a Skilled Nursing Facility

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

For any eligible condition this Policy provides indicated benefits for Covered Expenses for:

- Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility.
- Payment of benefits for Skilled Nursing Facility services is subject to all of the following conditions:
- You and Your Family Members must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing Facility.
- The services must be consistent with the Illness, Injury, degree of disability and medical needs. Benefits are provided only for the number of days required to treat the Illness or Injury.
- You and Your Family Members must remain under the active medical supervision of a Physician treating the Illness or Injury for which You and Your Family Members are confined in the Skilled Nursing Facility.

Note: No benefits will be provided for:

- Personal items, such as TV, radio, guest trays, etc.
- Skilled Nursing Facility admissions in excess of the maximum covered days per Year.

Hospice Services

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

The Insured Person must be suffering from a Terminal Illness for which the prognosis of life expectancy is six months or less, as certified by his or her Physician, notice of which is submitted to Us in writing.

The Physician must consent to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must submit a written treatment plan to Us every 30 days.

To be eligible for this benefit, the provider must be appropriately licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of Terminal Illness. The provider must also be approved as a Hospice provider under Medicare and the Joint Commission on Accreditation of Health Care Organizations or by the appropriate agency of the state in which this Policy is sold.

Professional and Other Services

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

This Policy provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- Services of an anesthesiologist or an anesthetist;
- Outpatient diagnostic radiology and laboratory services;
- Radiation therapy, chemotherapy and hemodialysis treatment;
- Surgical implants, except for cosmetic and dental;
- Surgical procedures for sterilization (i.e., vasectomy, and or tubal ligations);
- Prostheses/Prosthetic appliances and devices, artificial limbs or eyes;
- Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.
- The first pair of contact lenses or the first pair of eyeglasses when required as a result of eye surgery;
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products;
- Infusion and Injectable Specialty Prescription Medications may require medical and pharmacy prior authorization; and
- Rental or purchase of medical equipment and/or supplies that meet all of the following requirements:
  - Ordered by a Physician;
  - Of no further use when medical need ends;
  - Usable only by the patient;
  - Not primarily for comfort or hygiene;
  - Not for environmental control;
  - Not for exercise; and
  - And manufactured specifically for medical use.

Note: Medical equipment and supplies must meet **all** of the above guidelines in order to be eligible for benefits under this Policy. The fact that a Physician prescribes or orders equipment or supplies does not necessarily qualify the equipment or supply for payment.

Cigna determines whether the item meets these conditions.

Rental charges that exceed the reasonable purchase price of the equipment are not covered.

Ambulance Services

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

This Policy provides benefits for Covered Expenses incurred for the following ambulance services:

- Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground or air service for transportation to and from a Hospital or Skilled Nursing Facility.
- Monitoring, electrocardiograms (EKGs or ECG's), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriate licensed person must render the services.
- Ambulance transportation is covered for emergency situations only, to the nearest facility capable of handling the emergency.

Services for Short Term Rehabilitative Therapy (Physical Therapy, Occupational Therapy, Chiropractic)

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

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

Benefits for the therapeutic use of heat, cold, exercise, electricity, ultraviolet light, manipulation of the spine, or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury are payable up to the maximum number of visits as stated in the Benefit Schedule.

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.

Special Note:
Additional visits for Physical or Occupational Therapy may be covered following severe trauma such as:

- an inpatient hospitalization due to severe trauma, such as spinal Injury or stroke; and
- Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment; and
- Cigna authorizes this in advance.

Services for Cardiac Rehabilitation

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

This Policy 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.

Habilitative Services

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

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

Benefits for services 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 payable up to the maximum number of visits as stated in the Benefit Schedule.

Benefits for Covered Expenses will be provided for the necessary care and treatment of loss or impairment of speech, payable up to the number of visits as stated in the Benefit Schedule.

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.

Special Note:
Additional visits for Habilitative Services may be covered if Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment. Cigna must authorize any such additional visits in advance of treatment being provided.

Services for Mental, Emotional, Functional Nervous Disorders, Serious Mental Illness and Substance Use Disorder

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

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 Insured Person 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 Insured's condition.
- Inpatient Services must be received in a Hospital or Day Care Center for inpatient treatment.

Dental Care

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

This Policy provides benefits for dental care for an accidental Injury to natural teeth, subject to the following:

1. services must be received during the 24 months following the date of Injury;
2. no benefits are available to replace or repair existing dental prostheses even if damaged in an eligible accidental Injury; and
3. damage to natural teeth due to chewing or biting is not considered an accidental Injury under this Policy.

Pregnancy and Maternity Care

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

Your Participating Provider Plan provides pregnancy and post-delivery care benefits for You and Your Family Members

All comprehensive benefits described in this Plan are available for maternity services. Comprehensive Hospital benefits for routine nursery care of a newborn child are available so long as the child qualifies as an Eligible Dependent as defined in 'Conditions of Eligibility' in the section of this Plan titled "Who is Eligible for Coverage?".

The mother and her newborn child shall be entitled to inpatient Hospital coverage for a period of 48 hours following an uncomplicated vaginal delivery; and 96 hours following an uncomplicated delivery by cesarean section. If a decision is made between a mother and doctor to discharge a mother or newborn child from inpatient care before the 48 or 96 hour time period, coverage for timely post-delivery care is available.

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

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.

Newborn/Infant Hearing Screening

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

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

The Insured Person is not responsible for any additional payment for Covered Expense for Participating and Non-Participating Providers other than coinsurance and charges in excess of reasonable charges if a Non-Participating Provider is used. The Insured Person will not be subject to any deductibles or dollar limit whether a Participating Provider or a Non-Participating Provider is used.

Speech and Hearing

Payment will be provided for the following hearing services for an Insured Person 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.

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.

Early intervention services for treatment of developmental delays for children will be not be subject to any Policy limits for Physical, Occupational Therapy and speech therapy.

Reconstructive Surgery for 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.

All Preventive Care Services

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

The Plan provides benefits for routine preventive care services. Payment will be provided for Covered Expenses for preventive care services including the following:

- Routine physical exams.
- Annual mammogram for women, Pap test including cervical cancer screening and human papillomavirus testing, colorectal cancer testing and Prostate Specific Antigen testing (PSA).
- Items or services that been an A or B rating in current recommendations of the U.S. Preventive Services Task Force (USPSTF);
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved, including childhood immunizations;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- For women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- 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 Policy; 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 of the Policy for more information.

Detailed information is available at: www.healthcare.gov/center/regulations/prevention/recommendations.html

Note: Covered Services do not include routine examinations, care, screening or immunization for travel, employment, school or sports.

Cervical and Ovarian Cancer and Human Papillomavirus Testing

This Policy provides benefits for Covered Expenses made for an annual medically recognized diagnostic examination for the early detection of cervical and 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.

Childhood Immunizations

This Policy provides benefits for immunizations for children. These immunizations will include: (a) diphtheria; (b) Haemophilus influenzae type b; (c) hepatitis B; (d) measles; (e) mumps; (f) pertussis; (g) polio; (h) rubella; (i) tetanus; (j) varicella (chicken pox); (k) rotavirus; and (l) any other children's immunizations required by the State Board of Health. A deductible, copayment, or coinsurance is not required for immunizations.

Colorectal Cancer Testing

This Policy provides benefits for Covered Expenses for or in connection with a medically recognized screening exam for the detection of colorectal cancer for each Insured Person who is at normal risk for developing colon cancer. Coverage will include: (a) an annual fecal occult blood test; and either (b) a flexible sigmoidoscopy performed every five years; or (c) a colonoscopy performed every 10 years.

Prostate Testing

This Policy provides benefits for Covered Expenses made for or in connection with annual diagnostic examinations for the detection of prostate cancer, regardless of medical necessity; and an annual prostate-specific antigen (PSA) test for each covered man.

Mammogram Screening

This Policy provides benefits for Covered Expenses made for or in connection with an annual mammogram for each covered female.

Genetic Testing

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

This Policy provides benefits for Covered Expenses for charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

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

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

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 an Insured Person 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.

Autism Spectrum Disorders

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

This Policy provides benefits for Covered Expenses for Insured Persons for charges made for:

- diagnosis of Autism Spectrum Disorders; and
- treatment of Autism Spectrum Disorders.

Treatment for Autism Spectrum Disorders shall include the following care prescribed, provided, or ordered for an individual diagnosed with an Autism Spectrum Disorder 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.
3) 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.

Organ and Tissue Transplants

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

This Policy provides benefits for Hospital and professional services as described in this Policy for:

- An Insured Person who receives the organ or tissue.
- An Insured Person who donates the organ or tissue.

- An organ or tissue donor who is not an Insured Person, if the organ or tissue recipient is an Insured Person.

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

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.

All Transplant services received from non-Participating Providers are payable at the Out-of-Network level.

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. Transplant services received at Non-Participating Providers are covered at the Out-of-Network benefit 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.

Treatment of Diabetes

Medical services for Diabetes are covered on the same basis as any other medical condition. This Policy 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 Policy.

Treatment Received from Foreign Country Providers

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

Cigna does not accept assignments of benefits from Foreign Country Providers. You and Your Family Member can file a claim with Cigna for services and supplies from a Foreign Country Provider. The Insured Person at their expense is responsible for obtaining an English language translation of Foreign Country Provider claims and any medical records that may be required. Benefits are subject to all terms, conditions, limitations, penalties, and exclusions of this Policy and will not be more than would be paid if the service or supply had been received in the United States.

Home Health Care

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

The Policy provides benefits for Covered Expenses for Home Health Care when an Insured Person is confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. **Home Health services are limited to a combined maximum number of visits each Year as shown in the Benefit Schedule**. If the Insured Person is a minor or an adult who is dependent upon others for non-skilled care, custodial services and/or activities of daily living (e.g., bathing, eating, etc.), Home Health Care will be covered only during times when there is a family member or care giver present in the home to meet the Insured Person's non-skilled care and/or custodial service needs. Covered Services are limited to patient care that is determined to be Medically Necessary by Us. For purposes of this provision a Home Health Care visit is defined as up to 2 hours of Medically Necessary care per visit, with a maximum of 4 visits per day, prescribed by a Physician in lieu of hospitalization. Home Health Care Services must be provided by one of the following providers:

- Services of a registered nurse.
- Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.
- If the Insured is receiving the services of either of the above, the services of a health aide who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association also are covered. Such services must be ordered and supervised by a registered nurse who is employed as a professional by the same organization.
- Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association.
- Services of a medical social worker.

Private duty nursing services are not covered, even if provided as part of a home health care treatment program.

Smoking Cessation

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

This Policy provides benefits for Covered Expenses for two Smoking Cessation Attempts, as defined in the Policy, per Year per Insured Person.

Mastectomy and Related Procedures

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

This Policy provides benefits for Covered Expenses for hospital and professional services under this Policy for:

- mastectomy and lymph node dissection for the treatment of breast cancer and;
- treatment of physical complications of all stages of mastectomy and reconstruction, including lymphedemas, whether or not the mastectomy occurred while the Insured Person was covered under this Policy.

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 cancer.

When the Insured Person elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses.

Coverage for reconstructive breast surgery will not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the Policy definition of "Medically Necessary." Benefits will be payable on the same basis as any other Illness or Injury under the Policy.

Treatment for Temporomandibular Joint Dysfunction (TMJ)/Orthognathic Surgery

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

This Policy 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 Policy for any diagnosis, including TMJ.

Acquired Brain Injury

Medical services for Acquired Brain Injury are covered on the same basis as any other medical condition. This Policy provides benefits for Covered Expenses for Medically Necessary services for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment, neurofeedback therapy, remediation, post-acute transition services and 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:

- Acquired brain injury--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.

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 Policy for a complete description of the services.

Benefits Provided by the Texas Department of Human Services

All benefits payable under this Policy on behalf of a dependent child insured by this Policy 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 Policy 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.

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 Policy 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).

Nutritional Formulas: Amino Acid-Based Elemental Formula

This Policy 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.

Foot Disorders – Routine Services

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

External Prosthetic Appliances and Devices

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)
This Policy 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 utilization review Physician.

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 designed to replace wholly or partly, an arm or leg. 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:

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

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;

- orthosis shoes, 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.

Exclusions And Limitations: What Is Not Covered By This Policy

Excluded Services

In addition to any other exclusions and limitations described in this Policy, there are no benefits provided for the following:

- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed** as Covered Services in this Policy.
- Services or supplies that are **not Medically Necessary**.
- Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures**.
- Services received **before the Effective Date** of coverage.
- Services received **after coverage under this Policy ends**.
- 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.
- 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 Insured Person does not claim those benefits.
- 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) an Insured Person participating in the **military service** of any country; (d) an Insured Person 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 Insured Person being engaged in an illegal occupation.**
- Any services provided by a local, state or federal **government agency,** except (a) when payment under this Policy 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.
- Any services required by state or federal law to be supplied by a public school system or school district.
- **If the Insured Person is eligible for Medicare** part A, B or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
- **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- 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.
- Professional **services or supplies 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 Insured Person's home, or that person's employer;
  - a person who is related to the Insured Person 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.

- Custodial Care.
- **Private duty nurse**.
- Inpatient room and board charges in connection with a **Hospital stay primarily for environmental change or physical therapy**; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
- **Assistance in activities of daily living**, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or convalescent care.
- Inpatient room and board charges in connection with a Hospital stay primarily for **diagnostic tests** which could have been performed safely on an outpatient basis.
- **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 Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **Dental Implants**: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
- **Hearing aids**, except as specifically stated in this Policy.
- **Routine hearing tests** except as specifically provided in this Policy under "Comprehensive Benefits, What the Plan Pays For".
- **Genetic screening** or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Outpatient **speech therapy**, expect as specifically provided in this Policy.
- **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self-esteem or to treat psychological or psychosocial complaints regarding one's appearance including macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
- 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.
- Aids or devices that assist with nonverbal communication, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books except as specifically stated in this Policy.
- **Non-Medical counseling or ancillary services**, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety.
- Services for redundant skin surgery, removal of skin tags, acupressure, acupuncture, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.
- Treatment of **sexual dysfunction** impotence and/or inadequacy.
- All services related to the **evaluation or treatment of fertility and/or Infertility,** including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including

sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in this Policy.

- 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-injectable medications) **that do not require Physician supervision.**
- **All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision** and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, and **Self-administered Injectable Drugs**, except as stated in the Benefit Schedule and in the Prescription Drug Benefits Schedule.
- **Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision,** except as otherwise stated in this Policy. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- Fees associated with the **collection or donation of blood or blood products**, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration **for the purpose of general improvement in physical con**dition.
- **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- **Orthopedic shoes** (except when joined to braces), shoe inserts, foot orthotic devices except as specifically stated under External Prosthetic Appliances and Devices in the Benefits section of this Policy.
- Services primarily for **weight reduction** or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Insured Person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
- **Routine physical exams or tests** that do not directly treat an actual Illness, Injury or condition, including those required by employment or government authority, physical exams required for or by an employer, or for school, or sports physicals, except as otherwise specifically stated in this Plan.
- Therapy or treatment **intended primarily to improve or maintain general physical condition** or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- 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.).
- Massage therapy.
- **Educational services** except for Diabetes Self-Management Training Programs and those offered by Cigna.
- **Nutritional counseling** or food supplements, except as stated in this Policy.
- **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts (except as specifically stated under External Prosthetic Appliances and Devices in the Benefits section of this Policy), air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this Policy.
- Any **Drugs**, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Policy. This includes, but is not limited to, items dispensed by a Physician.
- **All Foreign Country Provider** charges are excluded under this Policy except as specifically stated under Treatment received from Foreign Country Providers in the section of this Policy titles "Comprehensive Benefits What the Policy Pays For".

- **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 Insured Person's condition. Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet except as otherwise stated in this Policy.
- **Charges for which We are unable to determine Our liability** because the Insured Person 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.
- Charges for the services of a **standby Physician.**
- Charges for **animal to human organ transplants.**
- Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

Prescription Drug Benefits

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 and/or Coinsurance shown in the Benefit Schedule.

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 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 Coinsurance shown in the Benefit Schedule.

Your responsibility for covered Prescription Drugs and Related Supplies will always be the lowest of:

- the Copay or Coinsurance 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.

Covered Expenses

If the Insured Person(s), while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Benefit Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to You or Your Family Members by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When You or Your Family Members are issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

What Is Covered

- Outpatient Drugs and medications that Federal and/or State of Texas 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.
- All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.
- Contraceptive Drugs and devices approved by the FDA.
- Orally administered anti-cancer medications prescribed in connection with cancer chemotherapy treatments.
- 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 Insured Person'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 an Insured Person's 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 Insured Person is an 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 medical and pharmacy prior authorization.

Exclusions

The following are not covered under the Prescription Drug Benefits. No payment will be made for the following expenses:

- Drugs not approved by the Food and Drug Administration.
- Drugs available over the counter that do not require a prescription by federal or state law except insulin or as otherwise stated in this Policy; or specifically required under the Patient Protection and Affordable Care Act (PPACA).
- Drugs that do not require a Federal legend (a Federal designation for drugs requiring supervision of a Physician), other than insulin.
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin.
- 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.
- Infertility related drugs; except those required by Patient Protection and Affordable Care Act (PPACA).
- 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 drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
- Any drugs that are Experimental or Investigational as described under the Medical "Exclusions" section of the Policy; except as specifically stated in the sections of this Policy titled "Clinical Trials", "Clinical Trial Costs" and "Off Label Drugs".

- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals.
- 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.
- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies; except for those pertaining to Diabetic Supplies and Equipment.
- Implantable contraceptive products inserted by the Physician are covered under the Plan's medical benefits.
- Prescription vitamins (other than prenatal vitamins), dietary supplements, herbal supplements, and fluoride, other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA).
- 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;
- Injectable or 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 Policy.
- Medications used for travel prophylaxis, except anti-malarial drugs;
- 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 Insured's condition. Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Drugs obtained outside the United States, except for drugs obtained as part of emergency care received for the treatment of an Emergency Medical Condition as defined by the policy.
- Replacement of Prescription Drugs and Related Supplies due to loss or theft.
- Drugs used to enhance athletic performance.
- Drugs which are to be taken by or administered to the Insured Person while 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.
- Prescriptions more than one year from the original date of issue.

Limitations

Each Prescription Order or refill unless limited by the drug manufacturer's packaging, shall be limited as follows:

- Up to a 90 day supply, at a 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 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; or
- Tobacco cessation medications that are included on Cigna's Prescription Drug List are limited to two 90-day supplies per Year.
- Infusion and Injectable Specialty Prescription Medications may require medical and pharmacy prior authorization.

- 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 Policy Year 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 Policy 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 Policy 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 Your 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 Our claim system to allow the Insured Person 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 Insured Person that coverage for the Prescription Drugs or Related Supplies has been approved, the Insured Person should contact the Pharmacy to fill the prescription(s).

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

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

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

Reimbursement/Filing a Claim

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

If an Insured Person(s) purchase the Prescription Drugs or Related Supplies through a non-Participating Pharmacy, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed.

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
PO Box 188053
Chattanooga, TN 37422-8053

For mail-order Pharmacy claims;
Cigna Home Delivery Pharmacy
PO Box 1019
Horsham, PA 19044-1019
1-800-835-3784

Forms are also available online at myCigna.com.

If You or Your Family Members have any questions about the Prescription Drug benefit, call the toll-free customer service number on the back of Your ID card.

Pediatric Vision Benefits for Care Performed by an Ophthalmologist, Optometrist or Therapeutic Optometrist

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 Policy provided to an Insured Person 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 Coinsurance shown in the Benefit Schedule.

What is Covered

In-Network Covered Benefits for an Insured Person who is under age 19 include:

- Examinations – One vision and eye health evaluation by an Optometrist, Therapeutic 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 an Insured 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 Insured Person 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 Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- 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, Therapeutic Optometrist or Ophthalmologist, or frames for such lenses;
- care not listed in The Schedule;
- Other Exclusions and Limitations listed in this Policy

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.

Cigna Vision Providers

To find a Cigna Vision Provider, or to get a claim form, the Insured Person 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 an Insured Person(s) has an exam or purchases Materials from a Cigna Vision Provider they pay any applicable Copayment, Coinsurance or Deductible shown in the Schedule at the time of purchase. The Insured Person does not need to file a claim form.

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

Cigna Vision
Claims Department
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.

General Provisions

Third Party Liability

You agree to advise Us, in writing, within a reasonable time of Your claim against the third party and to take such action, provide such information and assistance, and execute such documents as We may reasonably require to facilitate enforcement of the claim. You also agree to take no action that may prejudice the rights or interests of Us under this Policy. Failure to provide notice of a claim or to cooperate with Us, or actions that prejudice our rights or interests, may be considered to be a material breach by Us and may subject You to legal action.

We may have a right to a lien, to the extent of benefits advanced, upon any recovery that You receive from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this Policy for the treatment of the Illness, disease, Injury or condition for which the third party is liable. We will be entitled to collect on our lien even if the amount recovered by or for the Insured Person (or his or her estate, parent or legal guardian) from or for the account of such third party as compensation for the Injury, Illness or condition is less than the actual loss suffered by the Insured Person.

Coordination of Benefits

The Coordination of Benefits (COB) provision applies when an Insured Person 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, coinsurance, 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 coinsurance amounts for which the insured 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 an insured 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 insured 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 policy 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, policyholder, 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, policyholder, 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, policyholder, 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 an Insured Person who is eligible for Medicare 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:

- An Insured Person who is eligible for Part A or Medicare without premium payment, but did not apply, or
- An Insured Person who is eligible for Part B of Medicare, but is not enrolled.

An Insured Person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for that person.

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 Policy. The alternate treatment plan must be mutually agreed to by Us, the Insured Person, 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 Policy at any other time or for the Insured Person.

For the purposes of this section, any reference to the Insured Person also refers to a representative or provider designated by an Insured Person to act on your behalf, unless otherwise noted. We want you to be completely satisfied with the care received. That is why we have established a process for addressing concerns and solving your problems.

The Plan may not engage in retaliatory action, including refusal to renew or cancellation of coverage, against the Insured Person because the Insured Person, or a person acting on behalf of the Insured Person, has filed a complaint against the Plan or appealed a decision of the Committee. The Plan may not engage in retaliatory action, including a refusal to renew or termination of the Plan, against a Physician or Participating Provider because the Physician or Participating Provider has, on behalf of the Insured Person, reasonably filed a complaint against the Plan or appealed a decision of the Compliant Appeals Committee.

When You Have a Complaint

We are here to listen and help. If an Insured Person has a complaint regarding a person, a service, the quality of care, an initial eligibility denial, a rescission of coverage, or contractual benefits not related to Medical Necessity, you can call our toll-free number, which appears on your Benefit Identification card, explanation of benefits, or claim form, and explain the concern to one of our Customer Service representatives. A complaint does not include: (a) a misunderstanding or problem of misinformation that can be promptly resolved by Cigna by clearing up the misunderstanding or supplying the correct information to the Insured person's satisfaction; or (b) the Insured Person and their provider's dissatisfaction or disagreement with an adverse determination. The Insured Person can also express that complaint in writing. Please write to us at the following address:

CIGNA
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your complaint, we will send a one page letter acknowledging the issue and the date on which we received the complaint no later than the fifth working day after we receive the complaint.

We will respond in writing with a decision 30 calendar days after we receive a complaint for a post service coverage determination. If more time or information is needed to make the determination, we will notify the Insured Person in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

The Insured Person may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize the Insured Person's life, health or ability to regain maximum function or in the opinion of his Physician would cause severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay. If you request that your 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 level-one appeal would be detrimental to your medical condition. CIGNA's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When a complaint is expedited, we will respond orally with a decision within the earlier of; 72 hours; or one working day, followed up in writing within 3 calendar days.

If an Insured Person is not satisfied with the results of a coverage decision, they can start the complaint appeals procedure.

Complaint Appeals Procedure

To initiate an appeal of a complaint resolution decision, the Insured Person must submit a request for an appeal in writing to the following address:

CIGNA
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

The Insured Person should state the reason why he or she feels the appeal should be approved and include any information supporting the complaint.. If an Insured Person is unable or chooses not to write, he or she may ask to register the appeal by telephone. Call or write to Us at the toll-free number or address on the Benefit Identification card, explanation of benefits or claim form.

The complaint review will be conducted by the Complaint Appeals Committee, which consists of at least three people. Anyone involved in the prior decision, or subordinates of those people, may not vote on the Committee. The Insured Person may present his or her situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received the request within five working days after the date we receive the request for a Committee review and schedule a Committee review. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify the Insured Person in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the review, We will provide this information to the Insured Person as soon as possible and sufficiently in advance of the decision, so that the Insured Person will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, We will provide the rationale to the Insured Person as soon as possible and sufficiently in advance of the decision so that the Insured Person will have an opportunity to respond.

The Insured Person will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

The Insured Person may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize the Insured Person's life, health or ability to regain maximum function or in the opinion of his or her Physician would cause severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within the earlier of; 72 hours; or one working day, followed up in writing within three calendar days.

When You have an Adverse Determination Appeal

An Adverse Determination is a decision made by Cigna that the health care service(s) furnished or proposed to be furnished to the Insured Person is (are) not Medically Necessary or clinically appropriate. An Adverse Determination also includes a denial by Cigna of a request to cover a specific prescription drug prescribed by the Physician. If an Insured Person is not satisfied with the Adverse Determination, he or she may appeal the Adverse Determination orally or in writing. The Insured Person should state the reason why he or she feels the appeal should be approved and include any information supporting the appeal. We will acknowledge the appeal in writing within five working days after we receive the Adverse Determination Appeal request. We will acknowledge an appeal related to a request for coverage related to acquired brain injury via direct telephone contact to the individual making the request within three days after we receive the Adverse Determination Appeal request.

The appeal of an Adverse Determination will be reviewed and the decision made by a health care professional not involved in the initial decision. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the review, We will provide this information to the Insured Person as soon as possible and sufficiently in advance of the decision, so that the Insured Person will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, We will provide the rationale to the Insured Person as soon as possible and sufficiently in advance of the decision so that the Insured Person will have an opportunity to respond. We will respond in writing with a decision within 30 calendar days after receiving the Adverse Determination appeal request.

The Insured Person may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize the Insured Person's life, health or ability to regain maximum function or in the opinion of his or her Physician would cause severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. If the Insured Person requests that the appeal be expedited based on (a) above, the Insured Person may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to the Insured Person's medical condition.

Cigna's Physician reviewer in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within the earlier of; 72 hours; or one working day, followed up in writing within three calendar days.

In addition, the treating Physician may request in writing a specialty review within 10 working days of our written decision. The specialty review will be conducted by a Physician in the same or similar specialty as the care under consideration. The specialty review will be completed and a response sent within 15 working days of the request. Specialty review is voluntary. If the specialty reviewer upholds the initial adverse determination they must provide the Insured Person's health care provider, who ordered the services, a reasonable opportunity to discuss the Insured Person's treatment plan and the clinical basis for the specialty reviewer's determination with a health care provider who is of the same specialty as the specialty reviewer. If the Insured Person remains dissatisfied, he or she is still eligible to request a review by an Independent Review Organization.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's Adverse Determination appeal process or if you feel your condition is life-threatening, you may request that your appeal be referred to an Independent Review Organization. In addition, your treating Physician may request in writing that Cigna conduct a specialty review. The specialty review request must be made within 10 days of receipt of the Adverse Determination appeal decision letter. Cigna must complete the specialist review and send a written response within 15 days of its receipt of the request for specialty review. If the specialist upholds the initial Adverse Determination, you are still eligible to request a review by an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the Policy.

There is no charge for you to initiate this independent review process and the decision to use the process is voluntary. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. You will receive detailed information on how to request an Independent Review and the required forms you will need to complete with every Adverse Determination notice.

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

Appeal to the State of Texas

You have the right to contact the Texas Department of Insurance for assistance at any time for either a complaint or an Adverse Determination appeal. The Texas Department of Insurance may be contacted at the following address and telephone number:

Texas Department of Insurance
333 Guadalupe Street
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the denial decision; (3) reference to the specific Policy provisions on which the decision is based; a description of the source of or the screening criteria used: (4) 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; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and (6) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process; notice of the independent review process; a copy of the request for review of independent review process form; and procedure for filing a complaint about the utilization review process. A final notice of adverse determination will include a discussion of the decision.

Relevant Information

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

Terms of the Policy

Entire Contract; Changes: This Policy, including the benefit schedule, specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements including but not limited to age, occupation, or other insurance, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

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.

Grace Period: 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. Please see "General Provisions", for further information regarding cancellation and reinstatement.

If You did not purchase Your Plan from 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 unless We notify the Insured Person at the billing address listed in Our records at least 30 days prior to any premium due date that We do not intend to renew this Policy, or the Insured Person notify Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

Cancellation: We may cancel this Policy 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 of the grace period for plans not purchased from the marketplace or the 61 day grace period for plans purchased from a state or federal marketplace.
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 committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.

5. When We cease to offer policies of this type to all individuals in Your class. In this event, Texas law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; (2) offer to each Insured Person 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 (3) act uniformly without regard to any health status related factors of an Insured Person.
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.

In the event of cancellation, We will promptly return the unearned portion of any premium paid:

- If You cancel Your Policy, 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 insured resided when the policy was issued.
- If We cancel the Policy, the earned premium shall be computed pro rata. Cancellation is without prejudice to any claim originating before the effective date of cancellation.

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

Reinstatement: If this Policy 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 Policy. However, if We require an application for reinstatement, We will only reinstate this Policy 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 Policy 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 Policy 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 Policy immediately before the due date of the defaulted premium, subject to any amendments or endorsements attached to the reinstated Policy.

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.

Renewal: This Policy renews on a Calendar Year basis.

Fraud: If the Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

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 Policy, and available for use by Insured Persons, include but are not limited to:

- 24-hour health information — You can call the Cigna HealthCare 24-Hour Health Information LineSM 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 Insured Person 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 Insured Person 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 Insured Persons understanding of their individual physical condition and improving their health; and
- to facilitate the Insured Persons' access to Physicians and facilities in the Cigna provider network.

- Support in finding and arranging care and daily living services – available 24/7/365, Cigna Everyday Resources helps You arrange for help in caring for Yourself and others allowing You to focus on Your recovery. Insured Persons receive qualified referrals for support services such as house cleaning, pet sitting, child care, elder care, lawn care, home maintenance, legal and financial services.
- 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 Insured Persons' 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. Insured Persons 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 Policy. Contact Us for details regarding any such arrangements.

Certificate of Creditable Coverage: If coverage under this Policy terminates for any Insured Person, We will furnish to that person a Certificate of Creditable Coverage containing the information required by the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191. An Insured Person may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. To obtain a certificate call the toll-free customer service number on the back of your ID card. Such a certificate may help the Insured Person to obtain future coverage. However, Cigna is responsible only for the accuracy of the information contained in any certificate We prepare. We have no responsibility for the determinations, made by any other health insurance issuer with respect to any coverage it provides, including whether or not or to what extent the information contained in the certificate is relevant to the other health insurance issuer's actions.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy 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.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured Person(s) are the only persons entitled to receive benefits under this Policy. FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF THIS POLICY AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.
- The Effective Date of this Policy is printed on the Cigna identification card and on the Policy specification page.
- Cigna is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care in any Hospital, Free-Standing Outpatient Surgical Facility Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.

- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

  Cigna
Individual Services
P. O. Box 30365
Tampa FL 33630-3365

- When the amount paid by Cigna exceeds the amount for which We are liable under this Policy, We have the right to recover the excess amount from the Insured Person unless prohibited by law.

- In order for an Insured Person to be entitled to benefits under this Policy, coverage under this Policy must be in effect on the date the expense giving rise to a claim for benefits is incurred. Under this Policy, an expense is incurred on the date the Insured Person(s) receives a service or supply for which the charge is made.

- We will pay all benefits of this Agreement directly to, Participating Hospitals, Participating Physicians, and all other Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured Person assigns benefits in writing no later than the time of filing proof of loss (claim), except for Foreign Country Provider claims. If We receive a claim from a Foreign Country Provider for a Medical Emergency, any eligible payment will be sent to the Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured Person for those services.

- Any payment of benefits in reimbursement for Covered Expenses paid by an eligible child, or the eligible child's custodial parent or legal guardian, will be made to the eligible child, the eligible child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the eligible child.

- Cigna will provide written notice to You within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Members may be materially and adversely effected.

- Continuation of Care after Termination of a Provider whose participation has terminated:

  Cigna will provide benefits to You or Your Insured Family Members at the Participating Provider level for Covered Services of a terminated Provider for the following special circumstances:

  - Ongoing treatment of an Insured Person up to the 90th day from the date of the provider's termination date.
  - Ongoing treatment of You or Your Family members who is past the 24th week of pregnancy, who has been diagnosed with a complication of pregnancy as defined in this Policy, through delivery and the first follow up check-up within six weeks of delivery.
  - Ongoing treatment of an insured that at the time of termination has been diagnosed with a terminal Illness, but in no event beyond 9 months from the date of the provider's termination date.

- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at the number on the ID card and We will provide the Insured Person with one, or visit our Web site, www.CIGNA.com.

- If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect. However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

- Failure by Cigna to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.
- If Insured Person(s) were covered by a prior Individual Cigna Policy that is replaced by this Policy with no lapse of coverage:
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical Policy does not require that the Insured Person selects a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available under this medical Policy. Notwithstanding, a Primary Care Physician may serve an important role in meeting health care needs by providing or arranging for medical care for each Insured Person. For this reason, We encourage the use of Primary Care Physicians and provide the opportunity to select a Primary Care Physician from a list provided by Cigna for each Insured Person. If the Insured person chooses to select a Primary Care Physician, the Primary Care Physician You select for Yourself may be different from the Primary Care Physician You select for each of your Family Members.

Changing Primary Care Physicians:

The Insured Person may request a transfer from one Primary Care Physician to another by contacting Us at the member services number on ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, The Insured Person will be notified for the purpose of selecting a new Primary Care Physician, if they choose.

Continuity of Care if Your Provider Leaves the Network

If Your Participating Provider ceases to be affiliated with Cigna’s network, We will notify You. Under certain medical circumstances, We may continue to reimburse Covered Expenses from Your provider at the Participating Provider benefit level even though he or she is no longer affiliated with Cigna's network. If you are undergoing an active course of treatment for an acute or chronic condition and continued treatment is Medically Necessary, You may be eligible to receive continuing care from the Non-Participating Provider for a specified time, usually up to 90 days, subject to the treating provider’s agreement. You may also be eligible to receive continuing care if You are in your second or third trimester of pregnancy. In this case, continued care may be extended through Your delivery and include a period of postpartum care.

You may request continuity of care from Cigna after your Participating Provider’s termination from Cigna's network; start by calling the toll-free number on your ID card. Continuity of care must be Medically Necessary and approved in advance by Us. Your provider must agree to accept our reimbursement rate and to abide by Our policies and procedures and quality assurance requirements. Continuity of care will cease upon the earlier of:

- Your treatment is successfully transitioned to a Participating Provider, or
- The length of time approved for continuity of care ends.

There may be circumstances when continued care by a provider no longer participating in Cigna’s network will not be available, such as when the provider loses his or her license, is terminated for cause, or retires.

How to File a Claim for Benefits

Notice of Claim: A written notice of claim must be given to the Us within 20 days after the date of the occurrence or beginning of any loss covered by the policy, or as soon after that date as is reasonably possible. A notice given by or on behalf of the Insured Person or the beneficiary to the Us at the address on Your ID card, or to any authorized agent of Cigna, with information sufficient to identify the insured, constitutes notice to Cigna.

There is no paperwork for claims for services from Participating Providers. You will need to show Your ID card and pay any applicable copayment; Your Participating Provider will submit a claim to Us for reimbursement. Claims for Emergency Services from Non-Participating Providers can be submitted by the provider if the provider is able and willing to file on Your behalf. If a Non-Participating Provider is not submitting on Your behalf, You must send Your completed claim form and itemized bills to the claims address listed on Your ID card

Unpaid Premiums: At the time of payment of a claim under this policy, any premiums then due and unpaid or covered by any note or written order may be deducted from the payment.

Claim Forms: You may get the required claim forms from www.cigna.com under HealthCare, Important Forms or by calling Member Services using the toll-free number on Your identification card.

When We receive the notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days after the giving of such notice, the claimant shall meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

Claim Reminders:

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CLAIM FORMS, OR WHEN YOU CALL YOUR Cigna CLAIM OFFICE.
  - YOUR MEMBER ID IS SHOWN ON YOUR ID CARD.
  - YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR ID CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM.

Proof of Loss: You must give Us written proof of loss within 15 months after the date of the loss, except in absence of legal capacity. Proof of loss is a claim form as described above. Canceled checks or receipts are not acceptable. Cigna will not be liable for benefits if it does not receive written proof of loss within this time period.

Assignment of Claim Payments:

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

We may, at Our option, make payment to You for the cost of any Covered Expenses for Emergency Services from a Non-Participating Provider even if benefits have been assigned. If payment is made to the Insured Person for Emergency Services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

We will recognize any assignment made under the Policy, if:

1. It is duly executed on a form acceptable to Us; and
2. a copy is on file with Us; and
3. it is made by a provider licensed and practicing within the United States.

We assume no responsibility for the validity or effect of an assignment.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims:

Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. Any benefits due You which are unpaid at Your death will be paid to Your estate.

CIGNA is entitled to receive from any provider of service information about You which is necessary to administer claims on Your behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, You have authorized every provider furnishing care to disclose all facts pertaining to Your care, treatment, and physical condition, upon Our request. You agree to assist in obtaining this information if needed.
Payments of benefits under this Plan neither regulate the amounts charged by providers of medical care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers. **Claim Determination Procedures Under Federal Law (Provisions of the laws of Texas may supersede.)**

Procedures Regarding Medical Necessity Determinations

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

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

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

Preservice Medical Necessity Determinations

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

If the determination periods above would (a) seriously jeopardize the Insured Person’s life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Insured Person’s health condition, cause them severe pain which cannot be managed without the requested services, Cigna will make the pre-service determination on an expedited basis. Cigna’s Physician reviewer, will defer to the determination of the treating Physician regarding whether an expedited determination is necessary. Cigna will notify the Insured Person or their representative of an expedited determination within 72 hours after receiving the request.

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

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

Concurrent Medical Necessity Determinations

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

Post-service Medical Necessity Determinations

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

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date the Insured Person or their representative responds to the notice.

Post-service Claim Determinations

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; (6) information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Physical Examination and Autopsy: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured Person for whom a claim is made, when and so often as We may reasonably require during the pendency of a claim under this Policy. In the case of death of an Insured Person, Cigna shall have the right and opportunity to make an autopsy where it is not prohibited by law.

Premiums

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. Please see "General Provisions", for further information regarding cancellation and reinstatement.

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. Please see "General Provisions," for further information regarding cancellation and reinstatement.

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

a. Deletion or addition of a new eligible Insured Person(s)

b. A change in age of any member which results in a higher premium

c. 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 Insured Persons in the same class and covered under the same Policy 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.

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, except as expressly permitted by Cigna in writing.