Connecticut General Life Insurance Company ("Cigna")
Individual
California Open Access 1000

Pre-existing Condition Limitations

Any services received on or within 6 months after the Effective Date of coverage **are not covered** if they are related to a **Pre-existing Condition** as defined in the Definitions section.

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY. *This outline of coverage provides a very brief description of some important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Connecticut General Life Insurance Company. It is, therefore, important that you* ***READ YOUR POLICY CAREFULLY!***

Notice of Ten-Day Right to Examine Policy

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 except for Federally Eligible Defined Individuals 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 CONNECTICUT GENERAL 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, or if any information concerning the medical history of any Insured Person has been omitted, You should advise the Company immediately regarding the incorrect or omitted information; otherwise, Your Policy may not be a valid contract.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY AND WILL NOT DUPLICATE MEDICARE BENEFITS.

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.**

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

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

For children, you may designate a pediatrician as the primary care provider.

Introduction

About This Policy

Your medical coverage is provided under a Policy issued by CONNECTICUT GENERAL 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 OMITTED 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 OMITTED 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.

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.

Independent Medical Review

You have the right to request an Independent Medical Review when you believe health care services have been improperly denied, modified or delayed by Cigna or a Participating Provider. Refer to the section of this Policy entitled "When you have a Complaint or Adverse Determination Appeal" for more information.

Accessing Health Care

To contact the Department of Insurance, for complaints regarding Your ability to access health care in a timely manner, write or call:

Consumer Affairs Division
California Department of Insurance
Ronald Reagan Building
300 South Spring Street
Los Angeles, CA 90013

Calling within California: 1-800-927-4357

Los Angeles Area and Outside California: 1-213-897-8921

The Department of Insurance should be contacted only after discussions with the insurer have failed to produce a satisfactory resolution to the problem.

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. REFER TO YOUR SCHEDULE OF BENEFITS FOR ADDITIONAL INFORMATION.

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 A 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. Prior Authorization does not guarantee payment of benefits. Coverage is always subject to other requirements of this Policy, such as Pre-existing Conditions, limitations and exclusions, payment of premium and eligibility at the time care and services are provided.

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: Certain Prescription Drugs also may require Prior Authorization by Cigna. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If the 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 Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

BENEFIT SCHEDULE

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **READ THE ENTIRE POLICY CAREFULLY!** Terminology such as **Deductible, Covered Expense,** and **Out-of-Pocket Maximum** are listed alphabetically in the "Definitions" section of the Policy.

NOTE:
The benefits outlined in the table below show the payment for Covered Expenses. Coinsurance amounts shown below are CIGNA's responsibility after any applicable deducible, access fee, or additional deductible has been met, unless otherwise indicated. Copayment amounts are the INSURED PERSON'S responsibility unless otherwise stated.

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual and any additional deductible(s), Access Fees. unless specifically waived.	IN-NETWORK (Based on Cigna contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Medical Benefits		
Annual Deductible Individual Family **Note:** Additional Deductibles may apply to specific benefits.	**In-Network Deductible** $1,000 $2,000	**Out-of-Network Deductible** $2,000 $4,000
Out-of-Pocket Maximum Individual Family The following do not accumulate to the Out of Pocket Maximum: Deductibles, Copayments, Pharmacy charges, Penalties and Policy Maximums	**In-Network Out-of-Pocket Maximum** $2,000 $4,000	**Out-of-Network Out-of-Pocket Maximum** $4,000 $8,000
Coinsurance	Cigna pays 70% of eligible charges. You and Your Family Members pay 30% of Charges after the Policy Deductible.	Cigna pays 50% of eligible charges. You and Your Family Members pay 50% of Charges after the Policy Deductible.

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual and any additional deductible(s), Access Fees. unless specifically waived.	IN-NETWORK (Based on Cigna contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Prior Authorization Program **Prior Authorization – Inpatient Services** **Prior Authorization – Outpatient Services** **NOTE:** Please refer to the section on Prior Authorization of inpatient and outpatient services for more detailed 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 Benefit Details".	Your Provider must obtain approval for inpatient admissions; or Your provider may be assessed a penalty for non-compliance. Your Provider must obtain approval for selected outpatient procedures and diagnostic testing; or Your provider may be assessed a penalty for non-compliance.	You and Your Family Member(s) must obtain approval for inpatient admission; or You may be assessed a $500 penalty for non-compliance You and Your Family Member(s) must obtain approval for selected outpatient procedures and diagnostic testing; or You may be assessed a $60 penalty for non-compliance
Pre-existing Condition Limitation applies *to Insured Persons age 19 and over only* (*but may be reduced by Insured Person's prior eligible Creditable Coverage. See the definition of Pre-existing Condition.)*	Yes	Yes
All Preventive Well Care Services Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details **Note**: Voluntary sterilization for men is covered at the regular plan benefit level.	100% Deductible waived	50%
Physician Services Office Visit Specialty Physician Office Visit Consultant and Referral Physician Services (including consultant, referral and second opinion services) **Please Note:** A Copayment applies for OB/GYN visits. If Your doctor is listed as a PCP in the provider directory, You or Your Family Member will pay a PCP Copayment. If Your doctor is listed as a specialist, You or Your Family Member will pay the specialist Copayment.	$30 Copayment $40 Copayment	50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual and any additional deductible(s), Access Fees. unless specifically waived.	IN-NETWORK (Based on Cigna contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Surgery in Physician's office Outpatient Professional Fees for Surgery Inpatient Surgery, Anesthesia, Radiation Therapy In-hospital visits Allergy testing and treatment/injections	70%	50%
Hospital Services Inpatient Hospital Services Emergency Admissions	70% 70%	50% In-Network benefit level until transferable to an In-Network Hospital then 50%
Maternity Care Services (Including Complications of Pregnancy) Initial visit to confirm Pregnancy **NOTE:** OB/GYN providers will be considered either a PCP or a Specialist depending on how the provider contracts with CG. All subsequent Prenatal visits, Postnatal visits and Physician's delivery charges (i.e., global maternity fee) Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist Delivery – Facility (Inpatient Hospital, Birthing Center)	PCP or specialist Office Visit Copay 70% PCP or specialist Office Visit Copay 70%	50%
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	70%	50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual and any additional deductible(s), Access Fees, unless specifically waived.	IN-NETWORK (Based on Cigna contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Emergency Services **Emergency Room ($100 Access Fee per visit, In- and Out-of-Network, waived if admitted)** **Ambulance** includes emergency transportation to the nearest facility only.	70% 70%	In-network benefit level for an Emergency Medical Condition, otherwise 50% In-network benefit level for an Emergency Medical Condition, otherwise 50%
Urgent Care	70%	In-network benefit level for an Emergency Medical Condition, otherwise 50%
Advanced Radiological Imaging (including MRI, MRA, CAT Scan, PET Scan)	70%	50%
All Other Laboratory and Radiology Services Physician's Office Free-standing lab or x-ray facility including outpatient facility Outpatient hospital lab or x-ray	70%	50%
Short-Term Rehabilitative Services Physical, Occupational, Speech Therapy *Maximum of 24 visits per Insured Person, per Calendar Year for all therapies In- and Out-of-Network combined*	70%	50%
Cardiac & Pulmonary Rehabilitation	70%	50%
Dental Care Limited to treatment for accidental injury to natural teeth within six months of the accidental injury Anesthesia for dental procedures for a dependent child under age 7	70%	50%
Phenylketonuria (PKU) Testing and Treatment Medical Foods *to treat PKU*	70%	50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual and any additional deductible(s), Access Fees. unless specifically waived.	IN-NETWORK (Based on Cigna contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Subacute Facilities *30 day maximum per Insured Person, per Calendar Year combined for all facilities listed, In- and Out-of-Network combined.*	70%	50%
Home Health Services *30 visits maximum per Insured Person, per Calendar Year, In- and Out-of-Network combined*	70%	50%
Temporomandibular Joint Dysfunction (TMJ/TMD)	70%	50%
Durable Medical Equipment	70%	50%
Hospice	70%	50%
Treatment of Autism/ ABA Therapy (applied behavioral analysis)	70%	50%
Severe Mental Illness at any age and Serious Emotional Disturbances of a Dependent child under age 18 Inpatient Outpatient	70% 70%	50% 50%
Mental, Emotional or Functional Nervous Disorders and Substance Abuse Inpatient *30 days maximum combined in and out of network per Insured Person, per Calendar Year* Outpatient *Maximum 20 visits combined in and out of network per Insured Person, per Calendar Year*	70% 70%	50% 50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual and any additional deductible(s), Access Fees, unless specifically waived.	IN-NETWORK (Based on Cigna contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
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 Lifesouce Transplant Network® Facility	100%	NOT APPLICABLE
Other Cigna Network Facility Contracted to Provide Transplant Benefits	70%	50%
Travel Benefit (Only available through Cigna Lifesource Transplant Network® Facility) *Travel Maximum per person per lifetime*	$10,000	NOT APPLICABLE
Out-of-Network Facility	NOT APPLICABLE	50%
Infusion and Injectable Special Prescription Medications and related services or supplies	70%	50%

BENEFIT INFORMATION	IN-NETWORK (Based on Cigna contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Prescription Drugs Benefits		
Brand Name Prescription Drug Deductible (not applicable to Generic Drugs) (Combined In and Out of Network Services)	$250 per Insured Person, per Calendar Year	$250 per Insured Person, per Calendar Year
***Cigna Pharmacy Retail Drug Program* (Maximum 30-day supply)**		
Drugs designated as Preventive by the Patient Protection and Affordable Care Act of 2010	100% Deductible waived per Prescription or refill	50% per prescription/refill
Generic drugs- *on the Prescription Drug List*	$10 Copayment per prescription/refill	50% per prescription/refill
Brand Name drugs designated as preferred- *on the Prescription Drug List with no Generic equivalent*	$35 Copayment per prescription/refill	50% per prescription/refill
Brand Name drugs with a Generic equivalent and drugs designated as non-preferred *on the Prescription Drug List*	$60 Copayment per prescription/refill	50% per prescription/refill
Self-administered injectables	Cigna pays 70%	50% per prescription/refill
***Cigna Tel-Drug Mail Order Drug Program* (Maximum 90-day supply)**		
Drugs designated as Preventive by the Patient Protection and Affordable Care Act of 2010	100% Deductible waived per Prescription or refill	N/A
Generic drugs- *on the Prescription Drug List*	$25 Copayment per prescription/refill	N/A
Brand Name drugs designated as preferred- *on the Prescription Drug List with no Generic equivalent*	$85 Copayment per prescription/refill	N/A
Brand Name drugs with a Generic equivalent and drugs designated as non-preferred- *on the Prescription Drug List*	$150 Copayment per prescription/refill	N/A
Self-administered injectables	Cigna pays 70%	N/A

How The Policy Works

This section describes Deductibles, Access Fees 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. See “Definitions” for a definition 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, 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.

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

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

Covered Expense 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 penalties and/or Deductibles.

Special Circumstances

Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule 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. Once the patient is stabilized and he/she can 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 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 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.

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. All Additional Deductibles apply to only certain provider or service types. Deductibles do not include any amounts in excess of Maximum Reimbursable Charges, Access Fees, Prescription Drug Copays, 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.

If the Insured Person submits a claim for services which have a maximum payment limit and the Deductibles are not satisfied, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward any applicable Deductible.

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 incurred from Participating Providers each Year before any benefits are available.
- If You cover other Family Member(s), 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 incurred from Non-Participating Providers each Year before any benefits are available.
- If You cover other Family Member(s), 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.

Additional Deductibles and Access Fees

This benefit Policy may contain Additional Deductibles or Access Fees, which are specific to certain benefits. Please see the Benefit Schedule for specific dollar amounts.

- Pharmacy: An Additional Deductible per Year will apply for Brand Name Prescription Drugs. Each Insured Person must meet the Prescription Drug Deductible each Year before receiving benefits for Brand Name Formulary and Non-Formulary Prescription Drugs. This Deductible is separate from other benefits and does not accumulate toward satisfying any other Deductible. See the section entitled "Prescription Drug Benefits".
- Emergency room services: An Access Fee per visit will apply, unless the visit results in an inpatient admission into that Hospital immediately following the Emergency room visit.

Out of Pocket Maximum

The Out of Pocket Maximums are the amount of Coinsurance 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, Copayments, Prescription Drug Copayments, Access fees, any Deductible amounts, any penalties, or any amounts in excess of other benefit limits of this Policy. Charges for Severe Mental Health and Serious Emotional Disturbances of a Dependent child under age 18 will apply to the Out of Pocket Maximum.

- 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 Member(s), the Family Out of Pocket Maximum will apply. 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

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 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, and
- Payable by the Insured Person.

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.

Exclusions And Limitations: What the Policy Does Not Cover

Excluded Services

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

- Conditions which are **pre-existing** as defined in the Definitions section.
- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed** in this Policy as Covered Services.
- 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 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.
- 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;** (f) an Insured Person **being intoxicated**, as defined by applicable state law in the state where the illness occurred or under the influence of illegal narcotics or non-prescribed controlled substances unless administered or prescribed by Physician**.**
- Any services provided by a local, state or federal **government agency,** except when payment under this Policy is expressly required by federal or state law.
- If the Insured Person is eligible for **Medicare** part A or 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.
- Any services for which payment may be obtained from any local, state or federal **government agency** (except Medicaid or Medi-Cal). 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.

- **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- **Custodial Care**.
- Inpatient or outpatient services of a **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.
- Treatment of **Mental, Emotional or Functional Nervous Disorders** or psychological testing except as specifically provided in this Policy. However, medical conditions that are caused by behavior of the Insured Person and that may be associated with these mental conditions are not subject to these limitations.
- **Smoking cessation** programs.
- Treatment of **substance abuse** except as specifically provided in this Policy.
- **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. However, Orthodotic Services which are an integral part of reconstructive surgery for Cleft Palate are covered.
- **Dental Implants**: unless they are an integral part of reconstructive surgery for Cleft Palate. 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** including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound, except as specifically stated in this Policy.
- Routine **hearing tests** except as provided under Well Baby and Well Child Care and Newborn Hearing Benefits.
- **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.
- 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, physical therapy, occupational therapy**, except 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 services that are **not specifically listed** in this Policy as Covered Services.
- **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.
- **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, and services, training, educational therapy or other non-medical ancillary services for learning disabilities and developmental delays.
- Services for **redundant skin surgery**, removal of skin tags, acupressure, carinosacral/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.
- Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to **sex change**.
- Treatment of **sexual dysfunction** impotence and/or inadequacy except if this is a result of an Accidental Injury, organic cause, trauma, infection, or congenital disease or anomalies.
- 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, except as specifically stated in this Policy.
- **Injectable drugs** ("self-injectable" medications) **that do not require Physician supervision** are covered under the Prescription Drug benefits of this Policy.
- **All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision** and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the Prescription Drug benefits of this Policy.
- **Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision,** except as otherwise stated in this Policy, if not provided by an approved Participating Provider specifically designated to supply that specialty prescription. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- 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.
- **Cryopreservation** of sperm or eggs.
- Fees associated with the **collection or donation of blood or blood products**, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration **for the purpose of general improvement in physical condition**
- **Orthopedic shoes** (except when joined to braces) or shoe inserts, including orthotics.

- 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, including 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.
- **Telephone, e-mail, and Internet consultations** or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters, unless provided via an approved internet-based intermediary.
- 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 Program, and as specifically provided or arranged 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; 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.
- **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically provided under the benefits for Physical and/or Occupational Therapy/Medicine.
- **Self-administered Injectable Drugs**, except as stated in the Prescription Drug Benefits section of this Policy.
- **Syringes**, except as stated in the Policy.
- 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 titled “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.

- 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.
- **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.

Pre-existing Condition Periods

Pre-existing Condition Limitation applies* to Insured Persons age 19 and over only*.

Any services received by the Insured Person, age 19 and over, on or within 6 months after the Effective Date of coverage will not be covered, if they are related to a Pre-existing Condition, as defined in the Definitions section of this Policy, which existed within a 6 month period preceding the Effective Date of coverage.

Creditable Coverage for Pre-existing Conditions

The exclusion for Pre-existing Conditions does not apply to an Insured Person under age 19, or to an Insured Person age 19 or older who was continuously covered for an aggregate of 18 months by Creditable Coverage, that was in effect up to a date not more than 63 days prior to the Effective Date of the Insured Person's coverage under this Policy, excluding any waiting period. Proof of Creditable coverage is required**.**

Creditable Coverage is coverage under any of the following:

- a self-funded or self-insured employee welfare benefit Policy that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001, et seq.);
- any group [or individual] health benefit Policy provided by a health insurance carrier or health maintenance organization; Part A or Part B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
- Chapter 55 of Title 10, United States Code;
- a medical care program of the Indian Health Service or of a tribal organization;
- a state health benefits risk pool;
- a health Policy offered under Chapter 89 of Title 5, United States Code;
- a public health Policy as defined by federal regulations, including coverage established or maintained by a foreign country;]
- a health benefit Policy under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); Title XXI of the federal Social Security Act or state children's health insurance program.

Exclusions

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

- drugs available over the counter that do not require a prescription by federal or state law except as otherwise stated in this Policy, or 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;
- Drugs and medications used to induce non-spontaneous abortions;
- Infertility drugs;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. 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 that coverage for AZT will be provided;
- Off Label Drugs, except as specifically provided in this Policy.
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;
- prescription vitamins (other than prenatal vitamins), herbal supplements and dietary supplements other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- 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;
- Drugs obtained outside the United States;
- 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 shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 90-day supply at a mail-order Pharmacy, unless limited by the drug manufacturer's packaging; or
- 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.

Pharmacy Formulary Exception Process/Prior Authorization – Coverage of New Drugs

Pharmacy Formulary Exception Process/Prior Authorization

Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If the 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 Prior Authorization for coverage of the Prescription Drugs or Related Supplies. 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, the 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, they 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 a specific Prior Authorization request, they should call Member Services at the toll-free number on the ID card.

Reimbursement/Filing a Claim

When the Insured Person purchases Prescription Drugs or Related Supplies through a retail Participating Pharmacy 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) 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:

Cigna
P.O. Box 1019
Horsham, PA 19044
1-800-TEL-DRUG
or
1-800-835-3784

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

When You Have a Compliant or an Adverse Determination Appeal

For the purposes of this section, any reference to "You", "Your" or "Member" also refers to a representative or provider designated by You to act on Your behalf, unless otherwise noted.
We want You to be completely satisfied with the care You receive. That is why We have established a process for addressing Your concerns and solving Your problems.

Start with Member Services

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

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

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

Internal Appeals Procedure

Cigna has a one step appeals procedure for appeals decisions. To initiate an appeal, You must submit a request for an appeal in writing, within 365 days of receipt of a denial notice, to the following address:

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

You should state the reason why You feel your appeal should be approved and include any information supporting Your appeal. If You are unable or choose not to write, You may ask to register Your appeal by telephone. Call us at the toll-free number on Your Benefit Identification card, explanation of benefits or claim form.

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

We will respond in writing with a decision within 30 calendar days after We receive an appeal for a required pre-service or concurrent care coverage determination (decision). We will respond within 30 calendar days after We receive an appeal for a post-service coverage determination. If more time or information is needed to make the determination, We will notify you in writing to request an extension of up to 30 calendar days and to specify any additional information needed to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Us in connection with the appeal, We will provide this information to You as soon as possible and sufficiently in advance of the decision, so that You will have an opportunity to respond. Also, if any new or additional rationale is considered by Us, We will provide the rationale to You as soon as possible and sufficiently in advance of the decision so that You will have an opportunity to respond.

Please note that the California Department of Insurance (CDI) does not require You to participate in Cigna's appeals review for more than 30 days although You may choose to do so. At the completion of

this 30-day-review period, when the disputed decision is upheld or Your case remains unresolved, You may apply to the CDI for a review of Your case.

You may request that the appeal process be expedited if, Your treating Physician certifies in writing that an imminent and serious threat to Your health may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health. If You request that your appeal be expedited, You 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 Your medical condition.
When an appeal is expedited, We will respond orally with a decision within 72 hours, followed up in writing. The CDI allows You to apply for an independent medical review after this expedited decision if you are unsatisfied with our determination.

Independent Medical Review Procedures

When the disputed decision is upheld or Your case remains unresolved after 30 days and when Your case meets the criteria outlined below, You are eligible to apply to the CDI for an Independent Medical Review(IMR). The CDI has final authority to accept or deny cases for the IMR process. If Your case is not accepted for IMR, the CDI will treat Your application as a request for the CDI itself to review Your issues and concerns. Prior to application for an IMR, You are free to seek other avenues of appeal with Cigna. If You choose to do so, You will not forfeit Your eligibility to apply for the IMR.

The Independent Medical Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the Policy.

There is no charge for You to apply for or participate in this IMR process. Cigna will abide by the decision of the Independent Medical Review Organization.

In order to qualify for an IMR, certain conditions must be met: (1) Your Physician has recommended a health care service as Medically Necessary and Cigna has disagreed with this determination, or (2) You have received urgent care or emergency services that a Physician has deemed Medically Necessary and Cigna has disagreed with this determination, or (3) in the absence of (1) and (2), You have been seen by a Physician for the diagnosis or treatment of the medical condition for which You are seeking an independent medical review and Cigna has determined these services as not Medically Necessary or clinically appropriate. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for an independent medical appeal under this process. You remain entitled to send such issues to the CDI for a Department review.

Appeal to the State of California

We will provide You with an application and instructions on how to apply to the CDI for an IMR. You must submit the application to the CDI within 180 days of Your receipt of our appeal review denial. In compelling circumstances, the Commissioner of Insurance may grant an extension.

The Independent Medical Review Organization will render an opinion within 30 days. If a delay would be detrimental to Your medical condition, You may apply to the Department for an expedited review of Your case. If accepted, the Independent Medical Review Organization will render a decision in three days.

You have the right to contact the California Department of Insurance for assistance at any time. The Commissioner may be contacted at the following address and fax number:

California Department of Insurance
Claims Service Bureau, Attn: IMR
300 South Spring Street
Los Angeles, CA 90013
Or fax to 213-897-5891

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;

(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. 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.

Arbitration

Cigna uses binding arbitration to settle disputes, including claims of medical malpractice and disputes relating to the delivery of services under the Policy. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. The parties to this contract, by entering into it, are giving up their constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute or medical malpractice, relating to the delivery of service under the Policy, and to any claims in tort, contract or otherwise, between individual(s) seeking service under the Policy, whether referred to as a Member, Subscriber, Dependent, Enrollee or otherwise (whether a minor or an adult), or the heirs-at-law or personal representatives of any such individual(s), as the case may be, and Cigna (including any of their agents, successors– or predecessors-in-interest, employees or providers.)

Renewability of the Policy

The Policy will renew except for the specific events stated in the Policy. You or Your Insured Family Members will become ineligible for coverage:

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with the Policy or coverage.
5. When We cease to offer policies of this type to all individuals in your class, California 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 of a covered individual who may become eligible for the coverage.
6. When We cease offering any plans in the individual market in California, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. You and Your Family Member(s) no longer live in the State of California.

Any cancellation shall be without prejudice for any claim for Covered Expense incurred before cancellation. We will provide a written cancellation notice to You, at least five (5) days prior to cancellation.

Premiums

The monthly premium amount is listed on the Policy specification page which was sent with this Policy. This monthly premium amount applies to individuals whose monthly payment is deducted directly from their checking account. If You pay quarterly, the quarterly premium amount due is 3 times the monthly premium.

You will be responsible for an additional $45 charge for any check or electronic funds transfer that is returned to Us unpaid.

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 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.