Cigna Health and Life Insurance Company may change the premiums of this Policy only once per Calendar Year, on January 1st at renewal, 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 Policy as You.

Cigna Health and Life Insurance Company ("Cigna")
Cigna California Bronze

Notice of 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 for enrollees under age 65, or within 30 days of receipt for enrollees age 65 and over, 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 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 intentional misrepresentation of material fact 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.

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 each Calendar Year. Cigna may change the premiums of this Policy once per Calendar Year on January 1st at renewal after 60 days' written notice to the Insured. However, We will not change the premium schedule for this Plan on an individual basis, but only for all Insureds in the same class and covered under the same Plan as You. Coverage under this Policy is effective at 12:01 a.m. Eastern time on the Effective Date shown on the Policy's specification page.

Signed for Cigna by:

Matthew G. Manders, President

Anna Krishtul, Coporate Secretary

Starting in January 2014, you cannot be denied health insurance because you have health problems or a pre-existing condition, and your health insurance premiums cannot be based on your health status. You may also qualify for low cost or free health insurance for yourself or your Dependents.

Covered California
You can buy health insurance through Covered California. The State of California set up Covered California to help people and families, like you, find affordable health insurance. You can use Covered California if you do not have insurance through your employer, Medi-Cal or Medicare.

You must apply during an open or special enrollment period. Open enrollment begins November 1, 2015 and ends January 31, 2016. If you have a life change such as marriage, divorce, a new child or loss of a job, you can apply during a special enrollment period.

Through Covered California, you may also get help paying for your health insurance:

Receive tax credits: You can use your tax credit to help pay your monthly premium.

- **Reduce your out of pocket costs:** Out-of-pocket costs are how much you pay for things like going to the doctor or hospital or getting prescription drugs.
- To qualify for help paying for insurance, you must:
  - Meet certain household income limits
  - Be a U.S. citizen, U.S. national or be lawfully present in the U.S.
  - Other rules and requirements apply.

Medi-Cal Is Changing Too
Free health insurance is available through Medi-Cal. Medi-Cal is California's health care program for people with low incomes. Starting in 2014, you can get Medi-Cal if:

- You are less than 65 years old
- Your income is low
- You are a U.S. citizen, U.S. national or lawfully present in the U.S.
- Your eligibility is based on your income. It is not based on how much money you have saved or if you own your own home. You do not have to be on public assistance to qualify for Medi-Cal. You can apply for Medi-Cal anytime. To qualify for Medi-Cal if you are over 65, disabled or a refugee, other rules and requirements apply.

For More Information
To learn more about Covered California or Medi-Cal, visit www.CoveredCA.com or call 800-300-1506. You can also call or visit your county social services office.

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 Dependents. 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.

Dental Services

If you opt to receive dental services that are not covered services under this Policy, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services (phone number appears on myCigna.com) or your insurance broker. To fully understand your coverage, you may wish to carefully review this Policy document.

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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 Dependent(s) who are covered under this Policy. You and all Dependent(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 Dependent(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 Dependent(s) covered under the Policy.

IF, WITHIN 2 YEARS AFTER THE EFFECTIVE DATE OF YOUR PARTICIPATION IN THE POLICY, WE DISCOVER YOU OR YOUR DEPENDENTS PERFORMED AN ACT OR PRACTICE CONSTITUTING FRAUD OR MADE AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACT, WE MAY RESCIND THIS COVERAGE AS OF THE DATE OF THE FRAUD OR INTENTIONAL MISREPRESENTATION. ADDITIONALLY, IF WITHIN 2 YEARS AFTER ADDING ADDITIONAL DEPENDENT(S) (EXCLUDING NEWBORN CHILDREN OF THE INSURED ADDED WITHIN 31 DAYS AFTER BIRTH), WE DISCOVER YOU OR YOUR DEPENDENTS PERFORMED AN ACT OR PRACTICE CONSTITUTING FRAUD OR MADE AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACT WE MAY RESCIND COVERAGE FOR THE ADDITIONAL DEPENDENT(S) AS OF THE DATE OF THE FRAUD OR INTENTIONAL MISREPRESENTATION. 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 FROM THE DATE OF THE FRAUD OR INTENTIONAL MISREPRESENTATION AND, IF CLAIM PAYMENTS EXCEED TOTAL PREMIUMS PAID , THEN CLAIMS PREVIOUSLY PAID BY CIGNA FROM THE DATE OF THE FRAUD OR INTENTIONAL MISREPRESENTATION 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.

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.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

Accessing Health Care

Participating Providers

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.

- Copayments, Deductible and Coinsurance amounts shown in the benefit schedule for this Policy reflect the amount an Insured Person will pay for In-Network and for Out-of-Network benefits. You will pay more in Deductible and Coinsurance when You use an Out-of-Network (Non-Participating) Provider. In addition, Non-Participating Providers can bill You for any balance due after Cigna has paid its full benefit.

Away From Home Care

If you or your Dependents need medical care while away from home, you may have access to a national network of Participating Providers through Cigna's Away-From-Home Care feature. Call the number on your I.D. card for the names of Participating Providers in other network areas.

Service Area

The term Service Area means the area in which Cigna has a Participating Provider network. Cigna's national network of Participating Providers is within the United States. Cigna's toll-free care line personnel can provide you with the names of Participating Providers.

Emergency Services

Benefits for services and supplies received outside the United States are covered only 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.

Services from Participating and Non-Participating Providers are available outside the Service Area, including emergency health care services.

If you or your Dependents need medical care, you may obtain a listing of Participating Providers by calling the number on your I.D. card. A listing of Participating Providers can also be found at www.Cigna.com.

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

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

1-877-484-5967

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

California Department of Insurance
Consumer Services Division
300 South Spring Street, South Tower
Los Angeles, CA 90013

Calling within California: 1-800-927-HELP (4357). TDD: 1-800-482-4TDD.

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.

If You or Your Dependents need medical care, You may obtain a listing of Participating Providers by calling the number on your I.D. card. A listing of Participating Providers can also be found at www.Cigna.com.

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. The term Prior Authorization means the approval that a Participating Provider must request and obtain for In-Network services, and that You must request and obtain for services from an Out-of-Network Provider from the Review Organization, prior to services being rendered, in order to receive the full benefit for certain Covered Services under this policy. Prior Authorization is the process used to certify:

- That a service is Medically Necessary; and
- That a service is performed at the most appropriate level of care (i.e. inpatient or outpatient); and
- For an inpatient Hospital stay, to certify the Medically Necessary number of inpatient days.

If a Covered Service is determined to be Medically Necessary, benefits will be provided as described in this Policy. However, if a Covered Service is determined to be not Medically Necessary, the Insured Person will be responsible for payment of the charges for that service. You, and Your Physician on Your Behalf, have the right to appeal decisions regarding Medical Necessity. For complete information on the appeals process, please refer to the section of this Policy titled "When You Have a Complaint or an Adverse Determination Appeal".

Prior authorization is required for the inpatient and outpatient services listed below. Your in-network Participating provider will obtain prior authorization for you.

PRIOR AUTHORIZATION IMPORTANT INFORMATION

For services received in-network, your Participating provider will obtain authorization for you. When You use a Participating Provider, any penalty for failure to obtain authorization is the responsibility of Your Participating Provider.

You are responsible for obtaining authorization for inpatient and outpatient services from an Out-of-Network Provider. When You use a Non-Participating provider, any penalty for failure to obtain authorization is Your responsibility.

To verify Prior Authorization requirements, whether prior authorization has already been done for You by Your Provider, or to request prior authorization for Out-of-Network services, You should call Cigna at the number on the back of your ID card.

Prior Authorization is required for all non-emergency inpatient hospital admissions, except as noted below, and for any of the admissions listed below. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION to a hospital or one of the other facilities listed below can result in You having to pay $500 of the amount normally paid by this plan as a penalty when You use an Out-of-Network facility.

Failure to obtain prior authorization for an Essential Health Benefit, as defined under California Insurance Code section 10112.27, will not result in a complete denial of coverage for that benefit. If Cigna does not cover the services, You will not have to pay the prior authorization penalty.

PRIOR AUTHORIZATION FOR INPATIENT SERVICES

You should request prior authorization before any medical and mental health or substance use disorder non-emergency treatment in a Hospital, except for maternity, as described below. In the case of an emergency admission, You should contact the Review Organization within 48 hours, or as soon as reasonably possible, after the admission to an Out-of-Network facility, or Your Provider should contact the Review Organization when you are admitted to an In-Network facility. Continued stay review should be requested, prior to the end of the certified length of stay, for continued Hospital confinement.

To verify Prior Authorization requirements for outpatient procedures and services, You should call Cigna at the number on the back of Your ID card.

Please note that emergency admissions that cannot be reviewed in advance will be reviewed for Medical Necessity post admission. (See "Retrospective Review" below.)

Inpatient Prior Authorization reviews both the necessity for the admission and the need for continued stay in the hospital. Prior Authorization is required for all non-emergency inpatient hospital admissions, except for maternity admissions or admissions related to mastectomy or lymph node dissection. Continued stay review should be requested, prior to the end of the certified length of stay, for continued Hospital confinement.

Prior Authorization requirements for inpatient services that are Covered Services under this Policy include the following

- All non-emergency inpatient Hospital admissions, including admissions for medical, mental health and substance use disorder, (with the exception of maternity admissions or admissions related to mastectomy or lymph node dissection) at a general hospital, psychiatric hospital or substance use disorder hospital. (Note: emergency inpatient Hospital admissions must be reviewed for Medical Necessity; if this cannot be done prior to the admission it will be done post-admission.)
- Skilled Nursing Facilities
- Extended Care, including Habilitation and Rehabilitation, Facilities
- Organ and Tissue Transplants
- Hospice Care Services
- Mental Health and substance use disorder services in a Residential Treatment Facility

PRIOR AUTHORIZATION OF OUTPATIENT SERVICES

Outpatient prior authorization refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures in the categories listed below, when performed as an outpatient in a Free-standing Surgical Facility, Other Health Care Facility, a Physician's office, or your home. You should call the toll-free number on the back of your I.D. card to determine if prior authorization is required before You have any outpatient diagnostic testing or procedures out-of-network. Outpatient authorization is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient

authorization should only be requested for non-emergency procedures or services, and should be requested at least 10 calendar days prior to having the procedure performed or the service rendered out-of-network.

Prior Authorization is also required for the outpatient procedures and services listed below. FAILURE TO OBTAIN PRIOR AUTHORIZATION FOR A SERVICE OR PROCEDURE MAY RESULT IN A PENALTY. REFER TO YOUR SCHEDULE OF BENEFITS FOR MAXIMUM PENALTY AMOUNTS. If Cigna does not cover the services because they were determined not to be Medically Necessary, You are responsible for all charges.

Prior Authorization can be obtained by You or Your Dependent(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 received out-of-network, at least 10 calendar days prior to having the procedure performed or the service rendered.

To verify Prior Authorization requirements for outpatient procedures and services, You should call Cigna at the number on the back of your ID card.

Outpatient procedures that are Covered Services under this Policy which require Prior Authorization include the following categories:

- Procedures that may be either cosmetic or therapeutic, such as nasal surgery to improve appearance versus nasal surgery to alleviate breathing problems, or breast surgery to improve appearance versus breast surgery to restore appearance following a mastectomy.
- CT, PET scans, MRI, MRA, nuclear cardiology
- Speech, Occupational and Physical Therapy
- Applied Behavior Analysis (ABA)
- Infertility Services
- Durable Medical Equipment
- Home Health Services
- Home Infusion Services
- Injectable drugs
- Specialty drugs
- Experimental or investigational procedures
- Back/Spine Procedures
- Partial Hospitalization
- Intensive Outpatient Psychiatric Treatment Programs
- Ear devices
- Oral Pharynx Procedures
- Orthotics and Prosthetics
- Radiation Therapy
- Sleep therapy
- Genetic testing
- For pediatric dental Insured Persons: Occlusal Orthotic Device for treatment of TMJ, and orthodontic treatment; for additional information please refer to “Covered Dental Expenses,

"REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS." and to the definition of Orthodontia in the Pediatric Dental section of this Policy.

PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. Prior Authorization does not guarantee payment of benefits, however, if Prior Authorization is obtained for a Covered Service, Cigna cannot deny payment for that service because it is not Medically Necessary. Coverage is always subject to other requirements of this Policy, such as 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.

Pharmacy Formulary Exception

Process/Prior Authorization – Coverage of New Drugs

Pharmacy Formulary Exception Process/Prior Authorization for Retail and Mail Order Pharmacies

The presence of Prescription Drugs and Related Supplies on the Prescription Drug List does not guarantee that the Insured Person will be prescribed that Prescription Drug and Related Supplies by his/her Participating Physician for a particular medical condition.

You may contact Member Services at the toll-free number found on Your Cigna HealthCare ID card to request a copy of the Prescription Drug List or to request information regarding whether a specific drug or drugs are on the Prescription Drug List. You can also access the Prescription Drug List through the Internet at www.cigna.com/ifp-drug-list.

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. Cigna shall also maintain an expeditious process by which Participating Providers may obtain authorization for Medically Necessary non-Prescription Drug List Drugs and Related Supplies. If Your Physician reasonably believes that there is a Medically Necessary reason to prescribe a non-Prescription Drug List Drug and/or Related Supplies, or wishes to request coverage for a Prescription Drug and/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 obtain the Prior Authorization form at https://cignaforhcp.cigna.com or by calling the Cigna customer service number on the back of the member's ID card. The Physician should make this request before writing the prescription.

If the Insured Person is advised at the Pharmacy that the prescription is for a non-Prescription Drug List Drug and/or Related Supplies and the Physician has not contacted Cigna for authorization, the Pharmacy will dispense the Prescription Drug and/or Related Supplies at the full retail cost of the non-Prescription Drug List drug. The Insured Person may request that the

Pharmacy contact the Insured Person's Physician to request a change to a Prescription Drug List medication or submit a request to Cigna for coverage of the non-Prescription Drug List Drug and/or Related Supplies as Medically Necessary. If the Insured Person's Physician is not available or the Pharmacy is not able to reach Cigna all Pharmacies have been instructed to dispense at least a three (3) day supply, but not more than a thirty (30) day supply at the applicable Copayment/Coinsurance. If after being contacted the Insured Person's Physician reasonably believes a change to a Prescription Drug List Drug and/or Related Supplies is appropriate, Cigna will notify both the Insured Person and the Participating Pharmacy. If after consultation with the Insured Person's Physician, the non-Prescription Drug List Drug and/or Related Supplies is approved as Medically Necessary, the Insured Person will continue to receive the non-prescription Drug List Drug and/or Related Supplies at the applicable Copayment/Coinsurance.

If the request for approval involves a Medically Necessary new non-Prescription Drug List Drug and/or Related Supplies or a refill non-Prescription Drug List Drug and/or Related Supplies where the Insured Person has no more of the Prescription Drug and/or Related Supplies, Cigna will make a decision and communicate it to all parties by telephone on the same day as receipt of the request from the Insured Person's Physician but in any event not more than twenty-four (24) hours from the time of receipt. Requests for refills where the Insured Person has more of the drug remaining will be made and communicated in writing to all parties within forty-eight (48) hours from the time of receipt of the request from the Insured Person's Physician.

The length of the authorization will depend on the diagnosis and the Prescription Drug and/or Related Supplies. If the request is denied, Your Physician and You will be notified that coverage for the Prescription Drugs and/or Related Supplies is not authorized.

Cigna shall not limit or exclude coverage for a Prescription Drug and/or Related Supplies for an Insured Person if the drug had previously been approved for coverage by Cigna for a medical condition of the Insured Person and the Insured Person's Physician continues to Prescribe the drug for the medical condition provided that the drug is appropriately prescribed, and is considered safe and effective for treating the Insured Person's medical condition. Nothing shall preclude the Physician from prescribing another drug, including a "generic" drug covered by Cigna that is medically appropriate for the Member. This section does not apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA).

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

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 Exception Request

You or Your Physician can submit a request for Cigna to make an exception and cover clinically appropriate Drugs not otherwise covered by this Plan. This is called a request for exception. In the

event that an exception request is granted, the Cigna must treat the excepted drug(s) as an essential health benefit.

Standard Exception Request
Your Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request a standard review of a decision that a Drug is not covered by the Plan. The Physician can obtain the Prior Authorization form at https://cignaforhcp.cigna.com or by calling the Cigna customer service number on the back of the Insured Person's ID card. The Physician should make this request before writing the prescription.

Cigna must make a determination on the standard exception request and notify the You or the prescribing Physician of its coverage determination no later than 72 hours following receipt of the request.

When Cigna grants a standard exception request, We will provide coverage of the non-formulary drug for the duration of the prescription, including refills.

Expedited Exception Request
You or Your Physician can request an expedited review based on exigent circumstances. Exigent circumstances exist when You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function or when You are undergoing a current course of treatment using a non-formulary drug.

Cigna must make its coverage determination on an expedited review request based on exigent circumstances and notify You and the prescribing Physician of its coverage determination no later than 24 hours following receipt of the request.

When Cigna grants an exception based on exigent circumstances, We will provide coverage of the non-formulary drug for the duration of the exigency.

External Prescription Request Review
If Cigna denies a request for a standard exception or for an expedited exception, You or the prescribing Physician can request that the original exception request and subsequent denial of such request be reviewed by an independent review organization.

Cigna must make its determination on the external exception request and notify You and the prescribing Physician of its coverage determination no later than 72 hours following its receipt of a standard exception request, and no later than 24 hours following its receipt of an expedited exception request.

If Cigna grants an external exception review of a standard exception request, We must provide coverage of the non-formulary drug for the duration of the prescription. If Cigna grants an external exception review of an expedited exception request, We must provide coverage of the non-formulary drug for the duration of the exigency.

Prior Authorization—Pediatric Orthodontic Dental Benefits:

Pediatric Orthodontic Dental Benefits requires Prior Authorization by Cigna. If Prior Authorization is required, Your Provider may call, or You may call, the phone number on Your ID card. Participating Providers will request Authorization for you, however You can also call to verify that the Authorization was done.

You or Your provider can appeal an adverse decision. For complete information on the appeals process, please refer to the section of this Policy titled “When You Have a Complaint or an Adverse Determination Appeal”.

CIGNA CALIFORNIA BRONZE Benefit Schedule

COST SHARE AMOUNTS DESCRIBE THE ENROLLEE'S OUT-OF-POCKET COSTS.
Deductible applies unless "No cost share" or "Deductible waived" appears below.

Other Plan Provisions		Participating Provider Cost Share	Non-Participating Provider Cost Share
Plan Deductible	Individual	$6,000 medical	$12,000 medical
	Family	$12,000 medical	$24,000 medical/
Other Deductible(s)	Pharmacy Deductible	$500 single Pharmacy deductible; $1,000 family Pharmacy deductible	$500 single Pharmacy deductible; $1,000 family Pharmacy deductible
	Individual Pediatric Dental Deductible	None	None
Out of Pocket Maximum	Individual (includes Pediatric Dental)	$6,500	$25,000
	Family (includes Pediatric Dental)	$13,000	$50,000
Prior authorization penalties listed below do not accumulate to the Out-of-Pocket Maximum			
Prior Authorization Services requiring prior auth. are listed on www.mycigna.com Prior authorization is required for the inpatient and outpatient services listed on pages 4 and 5 of this Policy.	Inpatient Services $500 penalty for failure to obtain authorization for inpatient services Outpatient Services $60 penalty for failure to obtain authorization for outpatient services	If You use a Participating Provider, Your Participating Provider will obtain prior authorization for inpatient and/or outpatient services for you. If prior authorization is not obtained by Your Participating Provider, the Provider is responsible for the penalty amount.	If You use a Non-Participating Provider You must obtain prior authorization for inpatient and/or outpatient services. If You do not obtain prior authorization, You are responsible for the penalty amount.
Common Medical Event	**Service Type**	**Participating Provider Cost Share**	**Non-Participating Provider Cost Share**
Visit to a heath care provider's office or clinic	Primary Care Physician	Visits 1-3: $70, (deductible waived); Visits 4+: $70 (deductible applies)	50%
	Specialist visit	Visits 1-3: $90, (deductible waived); Visits 4+: $90 (deductible applies)	50%
	Other practitioner office visit	$70	50%
	Preventive care/screening/immunization	No cost share	50%
Tests	Laboratory tests	$40, deductible waived	50%
	X-rays and diagnostic imaging	100%	50%
	Imaging (CT/PET scans, MRIs)	100% requires pre-authorization	50% requires pre-authorization
Drugs to treat illness or condition 30 day supply for retail / 90-day supply for home delivery	Tier 1 Generic drugs Retail and home delivery	100%, after Pharmacy deductible (up to $500 retail/$1250 home delivery maximum per prescription, before Pharmacy deductible is met)	50% retail after Pharmacy deductible / Not covered for home delivery
	Tier 2 Preferred brand drugs Retail and home delivery	100%, after Pharmacy deductible (up to $500 retail/$1250 home delivery maximum per prescription,	50% retail after Pharmacy deductible / Not covered for home delivery

			before Pharmacy deductible is met)	
	Tier 3 Non-preferred brand drugs Retail and home delivery		100%, after Pharmacy deductible (up to $500 retail/$1250 home delivery maximum per prescription, before Pharmacy deductible is met)	50% retail after Pharmacy deductible / Not covered for home delivery
	Tier 4 Specialty drugs Retail and home delivery		100%, after Pharmacy deductible (up to $500 retail/$1250 home delivery maximum per prescription, before Pharmacy deductible is met) requires pre-authorization The total amount of Coinsurance You pay for each Prescription Order of up to a 30 day supply of Oral anti-cancer medications prescribed in connection with cancer chemotherapy is limited to $200, after any applicable Deductible	50% retail after Pharmacy deductible requires pre-authorization / Not covered for home delivery The total amount of Coinsurance You pay for each Prescription Order of up to a 30 day supply of Oral anti-cancer medications prescribed in connection with cancer chemotherapy is limited to $200, after any applicable Deductible
Outpatient surgery	Facility fee (e.g., ASC) Physician/surgeon fees		100% 100% requires pre-authorization	50% 50% requires pre-authorization
Need immediate medical attention	Emergency room facility Emergency room physician Emergency medical transportation Urgent care		100% (deductible and ER coinsurance waived if admitted) 100% (deductible and ER coinsurance waived if admitted) 100% Visits 1-3: $120, (deductible waived); Visits 4+: $120 (deductible applies)	In-network cost sharing applies for Emergency Services treating an Emergency Medical Condition If emergency treatment is not for an Emergency Medical Condition, Out-of-Network cost sharing applies.
Hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fee		100% requires pre-authorization 100%	50% requires pre-authorization 50%
Mental health, behavioral health (including autism) and Substance Abuse	Mental Health	Inpatient	100% requires pre-authorization	50% requires pre-authorization
		Office Visits	Preventive Visits 1-3: $70, (deductible waived); Non-Preventive Visits 4+: $70 (deductible applies)	50%
		All Other Outpatient i.e. partial hospitalization, IOP, ABA	Preventive Visits 1-3: $70, (deductible waived); Non-Preventive Visits 4+: $70 (deductible applies) requires pre-authorization	50% requires pre-authorization
	Substance Abuse	Inpatient	100% requires pre-authorization	50% requires pre-authorization
		Office Visits	Preventive Visits 1-3: $70, (deductible waived); Non-Preventive Visits 4+: $70	50%

			(deductible applies)	
		All Other Outpatient i.e. partial hospitalization, IOP	Preventive Visits 1-3: $70, (deductible waived); Non-Preventive Visits 4+: $70 (deductible applies) requires pre-authorization	50% requires pre-authorization
Pregnancy	Prenatal care and preconception visits		No cost share	50%
	Delivery and all inpatient services	Hospital	100%	50%
		Professional	100%	50%
	Complications of pregnancy		100%	50%
	Elective abortion		100%	50%
Child eye care (ages 1 to 19	Eye exam (deductible waived)		No cost share	50%
	Glasses (1 pair per Calendar Year)		No cost share	Not covered
Child dental preventive/diagnostic care (ages 1 to 19)	Oral exam Preventive – cleaning Preventive – x-ray Sealants per tooth Topical fluoride application Space maintainers – fixed		No cost share	No cost share
Child basic dental services	Amalgam fill – 1 surface		20%	20%
Child dental major services	Root canal – molar Gingivectomy per quad Extraction – single tooth exposed tooth or erupted Extraction – complete bony Porcelain with metal crown		50%	50%
Child orthodontics	Medically necessary orthodontics		50%	50%
Help recovering and other special health needs	Home health care (100 visits per year, requires prior authorization)		100%	50%
	Outpatient rehabilitation services (requires prior authorization)		$70	
	Outpatient habilitation services (requires prior authorization)		$70	
	Skilled nursing care (100 days per benefit period, requires prior authorization)		100%	
	Durable medical equipment (requires prior authorization)		100%	
	Hospice (requires prior authorization)		No cost share	

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.

Access Fee refers to an additional amount of Covered Expense which each Insured Person must pay for services specified by this Policy. When an Access Fee applies, benefits are calculated as follows: first the Access Fee is applied to the Covered Expense, then any other applicable Additional Deductible, Additional Copayment, and Deductible(s), Copayments or Coinsurance are applied in that order.

Additional Copayment means an additional fixed dollar amount applicable only to services specified by this Plan. When an Additional Copayment applies, benefits are calculated as follows: any applicable Access Fee applies, then the Additional Copayment; then any other applicable Deductible, then Copayments or Coinsurance are applied in that order. of Covered Expenses which the Insured Person must pay before any benefits are available for specific services (e.g., Brand Name Prescription Drug Pharmacy Deductible).

Additional Deductible means an additional amount of Deductible that applies only to services specified by this Plan. When an Additional Deductible applies, benefits are calculated as follows: any applicable Access Fee applies, then the Additional Deductible; then any other applicable Deductible, then Copayments or Coinsurance are applied in that order.

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 or Pervasive Developmental Disorders means Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified (including Atypical Autism), in accordance with the Diagnostic and Statistical Manual for Mental Disorders -IV - Text Revision (June 2000).

Brand Name Prescription Drug (Brand Name) means 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, or an affiliate. Cigna is a licensed and regulated insurance company operating throughout the United States.

Cleft Palate means a condition that may include cleft palate, cleft lip or other craniofacial anomalies associated with Cleft Palate.

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 and Reconstructive 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. Reconstructive Surgery is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including Medically Necessary dental or orthodontic services that are an integral part of Reconstructive Surgery for Cleft Palate procedures to do either of the following:
(1) To improve function.

(2) To create a normal appearance, to the extent possible.

Reconstructive Surgery also includes, “breast reconstruction”. For the purpose of this Policy, breast reconstruction means reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.

Coverage Area is any place that is within the state of California and within the counties, cities and/or zip code areas in the state of California that Cigna has designated as the area where this Plan is available for enrollment. For specific information regarding Your Service Area, please call the number on the back of your ID card.

Covered Expenses are the expenses incurred for Covered Services under this Policy which the terms of this Policy require Cigna to pay.. 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 the 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.

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

Dependent is

- "Child" means an Insured Person's, or a spouse's or registered domestic partner's adopted child, step-child, or child for whom you have assumed a parent child relationship, or recognized natural child, until attainment of age 26..
- "Disabled Dependent Child", for the purposes of this Policy, means Your own, or Your spouse's or Your domestic partner's child, as defined above, regardless of age, who is incapable of self-support due to medically certified continuing mental or physical disability, which existed continuously from a date prior to the child attaining age 26, and who is chiefly Dependent upon the Insured for support and maintenance.
- "Dependent" means the spouse or registered domestic partner, or child, of an individual, subject to applicable terms of the health benefit plan.

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

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

Diabetes Pharmaceuticals & Supplies include, but are not limited to, test strips for blood glucose monitors; visual reading and urine test strips; tablets which test for glucose, 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; pen delivery systems for the administration of insulin; syringes and needles, biohazard disposal containers, prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits.

Effective Date is the date on which coverage under this Policy begins for You and any of Your Dependent(s).

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

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

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: 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, device or medical treatment or procedure.

Family In-Network Deductible applies if You have a family plan and You and one or more of your Dependent(s) are Insured under this Policy. The Individual In-Network Deductible paid by each Dependent counts towards satisfying the Family In-Network Deductible. Each Insured Person can contribute up to the Individual In-Network Deductible amount toward 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 Dependent(s) will no longer be responsible to pay Deductibles, Coinsurance or Copayments 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 Out-of-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. Please note that cost share amounts paid to Out-of-Network Providers for Emergency Care accrue to the In-Network Out-of-Pocket Maximum. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Family Out-of-Network Deductible applies if You have a family plan and You and one or more of your Dependent(s) are Insured under this Policy. The Individual Out-of-Network Deductible paid by each Dependent counts towards satisfying the Family Out-of-Network Deductible. Each Insured Person can contribute up to the Individual In-Network Deductible amount toward the Family In-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 Dependent(s) will no longer be responsible to pay Deductibles, Coinsurance or Copayments 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. Please note that cost share amounts paid to Out-of-Network Providers for Emergency Care accrue to the In-Network Out-of-Pocket Maximum. 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.

Formula means an enteral product used in the home and prescribed by a Physician, nurse practitioner, or registered dietician for medically necessary treatment of PKU.

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 means services, including devices, that are provided for a person to attain, maintain, or prevent deterioration of a skill or function never learned due to a disabling condition. Rehabilitative services, including devices, are provided for a person to regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition."

Home Health Agencies and Visiting Nurse Associations are home health care providers that are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in Your home. They must be approved as home health care providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

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 per 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 Deductibles, Coinsurance or Copayments for medical services for Covered Expenses incurred during the remainder of that Year. The Individual In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Deductibles, Coinsurance or Copayments for medical services incurred from Participating Providers. Please note that cost share amounts paid to Out-of-Network Providers for Emergency Care accrue to the In-Network Out-of-Pocket Maximum. 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 Deductibles, Coinsurance or Copayments for medical services for Covered Expenses incurred during the remainder of that Year. The Individual Out-of-Network Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. Please note that cost share amounts paid to Out-of-Network Providers for Emergency Care accrue to the In-Network Out-of-Pocket Maximum. 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 precertification and will only be covered when provided by a Participating Provider.

Injury means a bodily injury to an Insured Person.

In-Network Out of Pocket Maximum is the maximum amount of Deductible, Copayment, charges for Infusion and Injectable Special Prescription Medications, and Coinsurance each Individual or Family incurs in Covered Expenses from Participating Providers in a Year. Note: Any coinsurance or copayments for covered Emergency services from an Out-of-Network Provider will count toward the In-Network Out-of-Pocket Maximum. All other services from an Out-of-Network Provider will only count toward the Out-of-Network Out-of Pocket Maximum.

Insured Is the person whose application has been accepted by Us for coverage under this Policy.

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

Materials for vision coverage means eyeglass lenses, frames, and/or contact lenses.

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

- The provider's normal charge for a similar service or supply; or
- A percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna; 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.

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 are determined by the Medical Director to be **all** of the following:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Within generally accepted standards of good medical practice within the community of qualified professionals.
- Not primarily for the convenience of any Insured Person, Physician, or another Provider.
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.
- The most appropriate procedure, supply, equipment or service which can be safely provided and that satisfies the following requirements:
    i) Must have been proven by scientific studies published in peer-reviewed medical literature to be associated with beneficial health outcomes, demonstrating that the expected health benefits are clinically significant and 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 or 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, other than Severe Mental Illness **or A** Serious Emotional Disturbance **for a Dependent child.**

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.

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, charges for Infusion and Injectable Special Prescription Medications, and Coinsurance each Individual or Family incurs in Covered Expenses from Non-Participating Providers in a Year. Note: Any coinsurance or copayments for covered Emergency services from an Out-of-Network Provider will count toward the In-Network Out-of-Pocket Maximum. All other services from an Out-of-Network Provider will only count toward the Out-of-Network Out-of Pocket Maximum.

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 Dental Services means routine dental care examinations, preventive treatment and other services or treatment described in the "Pediatric Dental Services" section of this Policy provided to an Insured Person who is under age 19.

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.

Penalties
A Penalty is an amount of Covered Expenses that is:

- Not counted toward any Deductible;
- Not counted toward the Out of Pocket Maximum;
- Not eligible for benefit payment once the Deductible is satisfied, and
- For Out-of-Network services, payable by the Insured Person.

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 in the state in which the Insured Person resides; 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, and in the completed and accepted application for coverage attached to this Policy, and any amendments or endorsements to this document.

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

Policy Year is defined as a 12-month period that begins on the first day of a Calendar Year.
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 Deductible means the Additional Deductible that an Insured Person or a Family must meet each Year before We will begin paying Covered Expenses for Preferred brand, Non-preferred brand, and Specialty drugs. This Additional Deductible is separate from Deductibles that apply to medical services but does accumulate toward satisfying the medical Out- of-Pocket Maximum(s).

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: (a) who is a general practitioner, internist, family practitioner, pediatrician and (b) 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, and equipment and other facility admissions require authorization in advance by Cigna to be eligible for benefits. If You, your Dependent 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.

Private Duty Nursing means nursing care (e.g., wound care, dressing changes, administration of medication) and other care (e.g., assistance with bathing, dressing, eating, toileting) performed by a licensed nurse or any other trained attendant in a patient's home or hospital room, separate from nursing care provided by the facility or home health care.

Prostheses/Prosthetic Appliances and Devices are fabricated replacements for missing body parts. Prostheses/Prosthetic Appliances and Devices include, but are not limited to:

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

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

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.

Review Organization refers to Cigna or another entity to which Cigna has authorized or delegated responsibility to perform utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Nurses, mental health and substance use disorder professionals, and other trained staff members who perform utilization review services.

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

Serious Emotional Disturbances

Serious emotional disturbances of a child means a child who

(1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and

(2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

Service Area means the area in which Cigna has a Participating Provider network. Cigna's national network of Participating Providers is within the United States. Other narrower networks may be only within a smaller area of the United States. Cigna's toll-free care line personnel can provide you with the names of Participating Providers.

Severe Mental Illness
A Severe Mental Illness is defined as: schizophrenia; bipolar disorder; obsessive-compulsive disorder; major depressive disorders; panic disorder; anorexia nervosa; bulimia nervosa; schizoaffective disorder; and pervasive developmental disorder or autism.

Sexual Dysfunction means any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

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, rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and 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 Food Products are those that are prescribed by a Physician or nurse practitioner for the treatment or PKU and are consistent with the recommendations and best practices of qualified health professionals with expertise in treatment and care of PKU. They do not include a food that is naturally low in protein. They may include a food product that is specially formulated to have less than one gram of protein per serving and is used instead of normal food products used by the general population, such as grocery store foods.

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

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 on the specification page.

Who Is Eligible For Coverage?

Eligibility Requirements

This Policy is for residents of the State of California. 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 not incarcerated, other than incarceration pending the disposition of charges; and
- You are a resident of the state of California; and
- You live within the Coverage 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 Dependent(s):

- Your lawful spouse or Your domestic partner who has registered the domestic partnership by filing a Declaration of Domestic Partnership with the California Secretary of State pursuant to Section 298 of the Family Code or an equivalent document issued by a local agency of California, another state, or a local agency of another state under which the partnership was created.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- A child for whom you have assumed a parent-child relationship who has not yet reached age 26. Cigna may request certification of a parent-child relationship at the time of enrollment and annually up to the age of 26.
- Your own, or Your spouse's or Your domestic partner'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 60 days of receiving Our request for written proof. After the original proof is received, Cigna may ask for proof of handicap/dependency every two years.
- Your own, or Your spouse's or Your domestic partner'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 paying any additional premium. Coverage for a newborn dependent child enrolled within 61 days of birth will be retroactive to the date of the child's birth.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage past that time You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date of placement for adoption or initiation of a suit of adoption, and paying 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 date 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.

NOTE: The Annual Open Enrollment Period begins on a specified date each Year. The Special Enrollment Period applies for a dependent acquired outside of the Annual Open Enrollment Period, and begins on the newborn's date of birth, or on the date of adoption or placement for adoption, or the date of a court order to provide coverage for an eligible child, and ends on the 61st day following that date.

Students Taking a Medically Necessary Leave of Absence

Students taking a Medically Necessary leave of absence are eligible for coverage for up to 12 months, though they will remain eligible for coverage only if they continue to meet all other eligibility requirements. Insureds age 26 or over who are eligible for coverage because they are students and who take a Medically Necessary leave of absence will remain covered until the earliest of the following dates:

- The date the leave ends;
- The date that is 12 months after the leave began;
- The date that coverage ends for a reason other than the insured's student status (for example, if the student reaches age 27).

Students who return to school after their leave ends are eligible if they meet all eligibility requirements. Documentation of the Medical Necessity for the leave must be submitted at least 30 days before the leave begins, if the absence and the medical reason for the absence are foreseeable. If the absence and the medical reason for the absence are not foreseeable, then documentation of the medical necessity for the leave must be submitted within 30 days after the leave begins.

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 Open Enrollment Period is a specified period of time each Year during which individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. Annual Open Enrollment for 2016 is November 1, 2015 – January 31, 2016. To be enrolled for coverage under this Plan, You must submit a completed and

signed application for coverage 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 enrolled in a health plan, as defined by PPACA, 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, or his or her eligible dependent(s), loses minimum essential coverage. For purposes of this paragraph, both of the following definitions shall apply:

  (i) "Minimum essential coverage" has the same meaning as that term is defined in subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

  (ii) "Loss of minimum essential coverage" includes, but is not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code. "Loss of minimum essential coverage" also includes loss of that coverage for a reason that is not due to the fault of the individual.

  (iii) Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to clause (ii) and Sections 10119.2 of the California Insurance Code and 10384.17 of the California Insurance Code.
- An eligible individual gains a dependent or becomes a dependent.
- An eligible individual is mandated to be covered as a dependent pursuant to a valid state or federal court order.
- An eligible individual has been released from incarceration.
- An eligible individual's health coverage issuer substantially violated a material provision of the health coverage contract.
- An eligible individual gains access to new health benefit plans as a result of a permanent move.
- An eligible individual was receiving services from a contracting provider under another health benefit plan, as defined in Section 10965 of the California Insurance Code, or Section 1399.845 of the Health and Safety Code for an acute condition, a serious chronic condition, a pregnancy, a terminal illness, the care of a newborn child between birth and 36 months of age, and a surgery or other procedure that is scheduled to occur within 180 days of the provider's termination date from the health benefit plan as described in subdivision (a) of Section 10133.56 of the California Insurance Code and that provider is no longer participating in the health benefit plan.

- An eligible individual demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the department, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.
- An eligible individual is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.
- An employee and his or her eligible dependent(s) lose coverage under an employer-sponsored health plan due to any of the following:
    - Reduction in work hours; or
    - Exhaustion of COBRA continuation coverage.
    - Termination of employer contributions toward premium; or
    - Termination of employment.
- An eligible individual's plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802-1(d)) that includes the individual.
- 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 eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the Coverage Area of the individual's current plan).

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 section 10384.17 of the California Insurance Code.

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 coverage effective dates determined as follows:

- In the case of birth, adoption, placement for adoption, or assumption of a parent/child relationship, coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or assumption of a parent/child relationship;
- In the case of marriage, or becoming a registered domestic partner, or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the month following the date Cigna received request for Special Enrollment.

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.
- With respect to Your Domestic Partner/spouse - when the spouse is no longer married to the Insured or when the Domestic Partnership is dissolved.
- With respect to You and Your Dependent(s) - when You no longer meet the requirements listed in the Conditions of Eligibility section;
- You and Your Dependent(s) no longer live within the eligible counties and/or zip code areas in the state of California for this Plan. For specific information regarding what counties and/or zip codes qualify, please check www.mycigna.com.
- The date the Policy terminates.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Dependent(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 other reason for the Insured's ineligibility stated in the Policy, except for the Insured's failure to pay premium, that Insured Person has the right to continuation of his or her insurance. Coverage will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Agreement 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 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. 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.

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 (except as specifically stated otherwise in the Benefit Schedule) incurred from Participating Providers each Year before any benefits are available.

If You cover other Dependent(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 (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 Dependent(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 Copayments

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

Out of Pocket Maximum

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. Charges for Severe Mental Health and Serious Emotional Disturbances of a Dependent child 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, Deductible, and Copayment 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. Note: Any coinsurance or copayments for covered Emergency services from an Out-of-Network Provider will count toward the In-Network Out-of-Pocket Maximum. All other services from an Out-of-Network Provider will only count toward the Out-of-Network Out-of Pocket Maximum.
- If you cover other Dependent(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, Deductible, and Copayment 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.

Penalties

A Penalty is an amount of Covered Expenses that is:

- Not counted toward any Deductible;
- Not counted toward the Out of Pocket Maximum(s);
- Not eligible for benefit payment once the Deductible is satisfied.

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 Covers

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 Dependent(s) 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 Dependent(s) 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

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

- Inpatient services and supplies provided by the Hospital.
- Short-term general Hospital services, including room with customary furnishings and equipment, meals (including special diets as Medically Necessary), general nursing care, use of operating room and related facilities, intensive care unit and services, drugs, medications, biologicals, anesthesia and oxygen services, diagnostic laboratory and x-ray services, special duty nursing as Medically Necessary, physical therapy, respiratory therapy, administration of blood and blood products, and other diagnostic, therapeutic and rehabilitative services as appropriate, and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization. Medically Necessary private room, specialized and critical care, DME and supplies, Physician services, radioactive materials, imaging and special procedures, occupational therapy, speech therapy, and medical social services are also covered.
- 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.

Emergency Services

This Policy covers benefits for Emergency Services anywhere in the world, in or out of network, so long as the services would have been otherwise covered, and that post-stabilization care (services related to the emergency medical condition) are also covered, including care at an out-of-network facility.

Emergency Services are available and accessible to enrollees on a 24-hour-a-day, seven-days-a-week basis. Emergency Services include ambulance services to transport the enrollee to the nearest 24-hour emergency facility with Physician coverage,

Urgent Care Services

Covered in-network so long as services would have otherwise been covered under the plan, and covered out-of-network if

a) services are received while the insured is temporarily outside the Service Area, and

b) insured reasonably believes that insured or insured's unborn child's health would seriously deteriorate if treatment was delayed until return to the Service Area.

Ambulatory Care Services

This Policy provides benefits for the following Ambulatory care services:
diagnostic and treatment services, physical therapy, speech therapy, occupational therapy services as appropriate, and those hospital services which can reasonably be provided on an ambulatory basis. Such services may be provided at a Hospital, any other appropriate licensed facility, or any appropriate facility which is not required by law to be licensed, if the professionals delivering such services are licensed to practice, are certified, or practice under the authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law.

Services and Supplies Provided by a Skilled Nursing Facility

This Policy provides benefits indicated for Covered Expenses. Payment of benefits for Skilled Nursing Facility services is subject to all of the following conditions:

Covered Expenses include: Physician and nursing Services, Room and board, drugs prescribed by a Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel, Durable medical equipment if Skilled Nursing Facilities ordinarily furnish the equipment, Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide, Medical social services, Blood, blood products, and their administration, Medical supplies, Physical, occupational, and speech therapy, Respiratory therapy.

- Benefits are subject to the day limits shown in the Schedule (100 days per benefit period) for a Skilled Nursing Facility. A benefit period begins on the date insured is admitted to a Hospital or Skilled Nursing Facility at a skilled level of care, and ends on the date insured has not been an

inpatient in a Hospital or Skilled Nursing Facility receiving a skilled level of care for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends.

- Inpatient services and supplies provided by the Skilled Nursing Facility.
- You and Your Dependents 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 Dependents must remain under the active medical supervision of a Physician treating the Illness or Injury for which You and Your Dependents 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

Hospice services means a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of an Insured Person who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family of the hospice patient. Hospice is available to insureds with a terminal illness (prognosis of life of one year or less).

Hospice services must comply with/include the following:

1) Hospice entity must be licensed in accordance with California Hospice Licensure Act of 1990 or a licensed home health agency with federal I certification (Health and Safety Code sections 1726 and 1747.1)
2) Interdisciplinary team care with development and maintenance of an appropriate plan of care.
3) Skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse.
4) Bereavement Services.
5) Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.
6) Medical direction with the medical director being also responsible for meeting the general medical needs of the enrollees to the extent that these needs are not met by the attending physician.
7) Volunteer services.
8) Short-term inpatient care arrangements.
9) Pharmaceuticals, medical equipment and supplies necessary for the palliation and management of the terminal illness and related conditions.

10) Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.

11) Covered services are to be made available on a 24 hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions.

12) Nursing care during periods of crisis: Nursing care services must be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an enrollee at home. Hospitalization must be covered pursuant to 1300.68.2(b)(2)(G), when the interdisciplinary team makes the determination that inpatient skilled nursing care is required at a level that cannot be provided in the home. Either homemaker or home health aide services or both may be covered on a 24 hour continuous basis during periods of crisis but the care provided during these periods must be predominantly nursing care. A period of crisis is a period in which the enrollee requires continuous care to achieve palliation or management of acute medical symptoms.

13) Respite Care: Respite care is short-term inpatient care provided to the enrollee only when necessary to relieve the Dependents or other persons caring for the enrollee. Coverage of respite care may be limited to an occasional basis and to no more than five consecutive days at a time.

Durable Medical Equipment

Durable Medical Equipment includes diabetic supplies, pediatric asthma supplies, laryngectomy supplies, prosthetic devices incidental to mastectomy.

1. Diabetic Shoes and Inserts: off-the-shelf depth-inlay shoes; custom-molded shoes; custom-molded multiple density inserts; fitting, modification, and follow-up care for podiatric devices; repair or replacement of podiatric devices.
2. Glucose Monitors, Infusion Pumps, and related supplies: external single or multiple channel electric or battery-operated ambulatory infusion pumps; home blood glucose monitors; interstitial glucose monitors; programmable and non-programmable implantable infusion pumps; infusion pump used for uninterrupted parenteral administration of medication; infusion sets for external insulin pumps; infusion supplies for external drug infusion pumps; calibrator solution/chips; single or multi-channel stationary parenteral infusion pumps; replacement batteries for home blood glucose monitors and infusion pumps; spring-powered device for lancet.
3. Respiratory Drug Delivery Devices: large and small volume nebulizers; disposable and non-disposable administration sets; aerosol compressors; aerosol mask; disposable and non-disposable corrugated tubing for nebulizers; disposable and non-disposable filters for aerosol compressors; distilled water for nebulizer; water collection device for nebulizer.
4. Tracheostomy Equipment: artificial larynx; replacement battery for artificial larynx; tracheo-esophageal voice prosthesis; tracheostomy supplies, including: adhesive disc, filter, inner cannula, tube, tube plug/stop, tube collar/holder, cleaning brush, mask, speaking valve, gauze, sterile water, waterproof tape, and tracheostomy care kits.
5. Canes and Crutches: adjustable and fixed canes, including standard curved handle and quad canes; adjustable and fixed crutches, including underarm and forearm crutches; replacement supplies for canes and crutches, including handgrips, tips, and underarm pads.
6. Dry pressure pad for a mattress.

7. Cervical traction equipment (over door).
8. Osteogenesis Stimulation Devices: non-invasive electrical osteogenesis stimulators, for spinal and non-spinal applications; non-invasive low density ultrasound osteogenesis stimulator.
9. Enteral and Parenteral Nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; supplies for self-administered injections.
10. Hospital grade breast pump and double breast pump kit.
11. IV Pole.
12. Phototherapy (bilirubin) light with photometer.
13. Compression burn garment; lymphedema gradient compression stocking; light compression bandage; manual compression garment; moderate compression bandage.
14. Non-segmental home model pneumatic compressor for the lower extremities.
15. Prosthetic Devices Incident to Mastectomy: prosthetic devices incident to a mastectomy, including custom-made prostheses when Medically Necessary; adhesive skin support attachment for use with external breast prosthesis; and brassieres for breast prostheses (3 brassieres every 12 months).
16. Prosthetic devices to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.
17. The following internally-implanted prosthetics must be covered when part of a covered surgery: pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints.

Coverage must include fitting and adjustment, repair or replacement (but not for loss or misuse), and services to determine whether an insured needs a prosthetic or orthotic device. Prescribed by a Physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license or is ordered by a licensed health care provider acting within the scope of his or her license.

Professional and Other Services

This Policy provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- Services of an anesthesiologist or an anesthetist;
- Allergy injections, including allergy serum, allergy test and treatment materials;
- Dental and Orthodontic Services in Preparation for Radiation Therapy, which includes dental evaluation, x-ray, fluoride treatment, and extractions necessary to prepare the jaw for radiation therapy of cancer in the head or neck;
- Dialysis Care. Acute and chronic dialysis services including the following: Inpatient dialysis; routine outpatient visits with multidisciplinary nephrology team for a consultation, exam, or treatment; hemodialysis; and home hemodialysis and peritoneal dialysis and necessary equipment and medical supplies provided insured receives appropriate training at a dialysis facility;

- Health Education Programs and Counseling including tobacco cessation and stress management education programs; Programs and materials to help insured protect and improve his/her health;
- Contraceptive services and devices provided by a Physician, including but not limited to: injectable Drugs and implants, intra-uterine devices (IUD), diaphragms, and the professional services associated with them;
- Radiation therapy, chemotherapy and hemodialysis treatment;
- Surgical implants, except for cosmetic or dental implants, unless they are an integral part of reconstructive surgery for cleft palate;
- Routine hearing screenings and hearing exams to determine the need for hearing correction. Hearing aids are not covered except internally-implanted devices;
- Internally implanted devices: Prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints are covered if they are implanted during a covered surgery;
- Consultation with and referral by Physicians to other Physicians. The plan may also include consultation and referral (Physician or, if permitted by law, patient initiated) to other health professionals who are defined as dentists, nurses, podiatrists, optometrists, physician's assistants, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists and other professionals engaged in the delivery of health services who are licensed to practice, are certified, or practice under authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law. Also, specialty care consultations, exams and treatment are covered;
- Ostomy and Urological Supplies: In general, these include adhesives, ostomy and hernia belts, catheters, drainage bags or bottles, dressing supplies, irrigation supplies, lubricants, miscellaneous supplies such as urinary connectors, gas filters, ostomy deodorants, plugs, caps, tubing, catheter leg straps, urinary pouches, skin barriers, ostomy rings, and tape. Incontinence supplies must be covered for hospice patients;
- Home hemodialysis and home peritoneal dialysis equipment and medical supplies;
- Surgical procedures for sterilization (i.e., vasectomy, and or tubal ligations);
- Education for pediatric asthma, including education to enable an enrollee to properly use a device.
- 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;
- Special Contact Lenses: Contact lenses for the treatment of aniridia (missing iris) and aphakia (absence of the crystalline lens of the eye) must be covered. Limited to up to 2 (aniridia) or up to 6 (aphakia) contact lenses per eye, including fitting and dispensing, in any 12-month period;
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products;

- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification;
- 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
    - 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.

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

Ambulance Services

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 ECGs), 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 and non-emergency situations, to the nearest facility capable of handling the emergency. Ambulance transportation by licensed ambulance is covered without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- A reasonable person would have believed that the medical condition was an Emergency Medical Condition which required Ambulance Services
- Your treating Physician determines that you must be transported to another facility because Your Emergency Medical Condition is not stabilized and the care You need is not available at the treating facility
- Non-emergency ambulance and psychiatric transport van services are covered if a physician determines that the insured's condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger insured's health. Services are only covered when the vehicle transports insured to or from covered services.

Non-emergency ambulance services do not include transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a provider.

Services for Habilitative Services and Rehabilitative Therapy - Physical Therapy, Occupational Therapy, Speech Therapy, and Acupuncture

This Policy provides benefits for Covered Expenses incurred 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.

Benefits for Covered Expenses will be provided for the necessary care and treatment of loss or impairment of speech.

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.

Acupuncture

This policy provides benefits for covered expenses incurred for medically necessary acupuncture services. All supplies and additional fees charged in conjunction with these medically necessary services will be included in the payment of benefits for the visit and will not be reimbursed in addition to the visit.

Services for Cardiac Rehabilitation

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.

Mental Health and Substance Use Disorder

Mental Health

Benefits are payable for services rendered to treat mental disorders as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders (DSM). Mental disorders are disorders that result in clinically significant distress or impairment of mental, emotional, or behavioral functioning including, but not limited to Severe Mental Illnesses; Serious Emotional Disturbances of a Child; Pervasive Development Disorders and Autism Spectrum Disorders.

Coverage does not include conditions that the DSM identifies as something other than a "mental disorder", such as relational problems. Couples counseling or family counseling for relational problems is not covered.

Coverage includes:

1. Outpatient services which are ambulatory services rendered to persons not confined to a facility and include:

   (a) Office Visits which refer to a visit by the Insured Person (who is the patient) to the office of a licensed behavioral health care professional (i.e. psychiatrist, psychologist, clinical social

worker) for the diagnosis and treatment of a mental disorder including, but not limited to medication management, individual psychotherapy, family psychotherapy, group psychotherapy, etc.; and

(b) "All Other Outpatient Services" which refer to more intensive outpatient services typically rendered in a facility or home setting including, but not limited to partial hospitalization, Intensive Outpatient Programs (IOP) and Applied Behavior Analysis (ABA) rendered by certified or licensed treatment programs or health care professionals.

2. Inpatient services including acute inpatient care rendered by psychiatric hospitals with 24-hour-a-day monitoring by clinical staff for stabilization and observation of acute psychiatric crises; and sub-acute services rendered by Residential Treatment Facilities.

Serious Emotional Disturbances of a Child/Severe Mental Illness

Benefits are payable for Medically Necessary treatment of Severe Mental Illness for covered persons of any age, and Serious Emotional Disturbances of a Dependent Child. When treatment is provided by a Participating Provider, Covered Expenses will be payable the same as for other Illnesses, including any deductibles, copayments, and coinsurance levels.

Treatment of Autism

This Policy provides benefits for Professional services and treatment programs for Pervasive Developmental Disorders or Autism, including applied behavior analysis (ABA), and evidence-based behavior intervention programs, that develop or restore to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or Autism and that meet all of the following criteria:

(A) The treatment is prescribed by a licensed Physician or is developed by a licensed psychologist.

(B) The treatment is provided under a treatment plan prescribed by a Qualified Autism Service Provider and is administered by one of the following:

- A Qualified Autism Provider.
- A Qualified Autism Service Professional supervised and employed by a Qualified Autism Provider
- A Qualified Autism service Paraprofessional supervised and employed by a Qualified Autism Service Provider.

(C) The treatment plan has measurable goals over a specific time-line that is developed and approved by the Qualified Autism Provider for the specific patient. The treatment plan should be reviewed no less than every 6 months by the Qualified Autism Provider and modified when appropriate. Within the treatment plan the Qualified Autism Provider shall do all of the following:

- Describes the patient's behavioral health impairments to be treated.
- Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goals and objectives, and the frequency at which the patient's progress is evaluated and reported.
- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorders or Autism.
- Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing/reimbursing respite care, day care or educational services and is not used to reimburse a parent for participating in the treatment program.

Qualified Autism Service Provider means either:

(A) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agents, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.

(B) A person licensed as a Physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist, who designs supervises, or provides treatment provided the services are within the experience and competence of the licensee.

Qualified Autism Service Professional means an individual who meets all of the following criteria:

(A) Provides behavioral health treatment.

(B) Is employed and supervised by a Qualified Autism Service Provider.

(C) Provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider.

(D) Is a behavioral service provider approved as a vendor by the California regional center to provide services as an Associate Behavioral Analyst.

Qualified Autism Service Paraprofessional means an individual who is unlicensed and uncertified but who meets all of the following criteria:

(A) Is employed and supervised by a Qualified Autism Service Provider.

(B) Provides treatment and implements services pursuant to a treatment plan developed and approved by a Qualified Autism Service Provider.

(C) Meets criteria noted in regulations required by Section 4686.3 of the Welfare and Institutions Code.

(D) Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

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.

Substance Use Disorder

Benefits are payable for services rendered to treat Substance use disorder as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders (DSM). Substance use disorder is a disorder in which the use of one or more

substances leads to a clinically significant impairment or distress. In determining benefits payable under the plan, charges made for the treatment of any physiological conditions related to rehabilitation services for Substance use disorder will not be considered to be charges made for the treatment of Substance use disorder. Medical complications of alcoholism, such as cirrhosis of the liver, gastrointestinal bleeding, pneumonia and delirium tremens will be covered as any other physical illness under the plan.

Coverage includes:

1. Outpatient services which are ambulatory services rendered to persons not confined to a facility and include:

   (a) Office Visits which refer to a visit by the Insured Person (who is the patient) to the office of a licensed behavioral health care professional (i.e. psychiatrist, psychologist, clinical social worker) for the diagnosis and treatment of a substance use disorder including, but not limited to individual, family and group chemical dependency counseling; and

   (b) "All Other Outpatient Services" which refer to more intensive outpatient services typically rendered in a facility setting including, but not limited to partial hospitalization, Intensive Outpatient Programs (IOP) and Detoxification Outpatient Programs rendered by licensed treatment programs.2. Inpatient services including acute inpatient services rendered by facilities with 24-hour-a-day monitoring by clinical staff for stabilization and observation of substance use disorder crises; detoxification and related medical ancillary services rendered for the diagnosis and treatment of substance use disorder; and sub-acute services rendered by Residential Treatment Facilities.

Dental Care

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 6 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.

This Policy also provides benefits for dental evaluation, x-ray, fluoride treatment and extractions necessary to prepare an Insured Person's jaw for radiation treatment for cancer of the head or neck.

Anesthesia for Dental Procedures for Dependent Children

Benefits are payable for general anesthesia/radiation therapy and associated facility charges for dental procedures rendered in a Hospital or Ambulatory Surgical Center for:

(a) a child;

(b) an individual who is developmentally disabled; or

(c) an individual whose health is compromised and general anesthesia is Medically Necessary.

Pregnancy and Maternity Care

Your Participating Provider Plan provides pregnancy and post-delivery care benefits for You and Your Dependents.

All comprehensive benefits described in this Plan are available for maternity services. Comprehensive Hospital benefits for care of a newborn child are available so long as the child qualifies as an Eligible Dependent as defined in 'Who is Eligible to Enroll Under this Plan' 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.

Coverage is provided for a post-discharge follow-up visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating Physician. The visit shall be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit shall include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments.

Coverage is provided for prenatal genetic testing for disorders (for which genetic counseling 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, the 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.

Alpha Feto Protein (AFP)

This Policy provides benefits for participation in the Expanded Alpha Feto Protein (AFP) program, which is a statewide prenatal testing program administered by the State Department of Health Services.

Sexual Dysfunction Services

This Policy provides benefits for Covered Expenses including services to diagnose conditions resulting in Sexual Dysfunction.

All Preventive Care Services

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.
- Mammogram for screening or diagnostic purposes upon the referral of a nurse practitioner, certified nurse-midwife, physician assistant, or Physician, providing care to the patient and operating within the scope of practice.

- Voluntary termination of pregnancy.
- Family planning counseling and education.
- Female sterilization procedures.
- All Food and Drug Administration (FDA) approved contraceptive methods (drugs and devices) for women as prescribed by a health care provider, including: (a) Over-the-counter FDA approved contraceptive methods for women as prescribed by a health care provider, and (b) Procedures to implant and remove internally implanted time-release contraceptives and intrauterine devices. This includes services relating to follow-up and management of side effects and counseling for continued adherence.
- Preventive vision screening.
- Hearing exams to determine the need for hearing correction (diagnostic audiometry).
- Health education counseling and programs for tobacco cessation and stress management.
- United States Preventive Services Task Force (USPSTF) for services rated “A” or “B”, Advisory Committee on Immunization Practices (HRSA) recommended wellness screening laboratory tests and procedures, and radiology procedures in connection with the examination.
- Routine Immunizations, including flu shots, tetanus shots, evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.
- 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.
- Annual cervical cancer screening test provided pursuant to this section shall include the conventional Pap test, a human papillomavirus screening test that is approved by the federal Food and Drug Administration, and the option of any cervical cancer screening test approved by the federal Food and Drug Administration, upon the referral of the patient's health care provider.
- Screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when Medically Necessary and consistent with good professional practice.
- This Policy provides benefits for comprehensive preventive pediatric care. All benefits recommended by the following two guidelines are covered:

  (1) The American Academy of Pediatrics Bright Futures Recommendations for Pediatric Preventive Health Care, and.

  (2) The Uniform Screening Panel recommended by the U.S. Department of Health and Human Services Secretary’s Discretionary Advisory Committee on Heritable Disorders in Newborns and Children.
- For women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including the full course of prenatal visits.
- Benefits are payable for human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
- Benefits are payable for vaccines for AIDS that are approved for marketing by the federal FDA and that are recommended by the United States Public Health Service. Coverage will not be provided for any clinical trials relating to an AIDS vaccine or for any AIDS vaccine that has

been approved by the federal Food and Drug Administration in the form of an investigational new drug application.

- Evidence-informed preventive care and screenings provided for in HRSA guidelines for infants, children, adolescents, and women. This includes prenatal care and preconception visits. Also included are well-woman visits; female sterilization; screening for gestational diabetes; HPV testing; counseling for sexually transmitted infections; counseling and screening for HIV; contraceptive methods and counseling; breastfeeding support supplies, and counseling; and screening and counseling for interpersonal and domestic violence. Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention.
- Benefits are payable for cancer screening tests that are based on generally accepted medical guidelines or scientific evidence.

Detailed information is available at www.healthcare.gov

Diagnostic Laboratory Services

Diagnostic and therapeutic radiological services, and other diagnostic services, which shall include, but not be limited to, electrocardiography and electroencephalography, X-rays, mammograms, ultrasounds; nuclear medicine; lab work: effectiveness of dialysis, fecal occult blood test, preventive care services, genetic disorder tests; Imaging (CT/PET Scans, MRIs); radiation therapy; ultraviolet light treatments; and bone density scans (CT and DEXA).

Genetic Testing

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.

Coverage provided for prenatal genetic testing for disorders (for which genetic counseling is available).

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.

Organ and Tissue Transplants

To be eligible for benefits, organ and tissue transplants must be Prior Authorized by Cigna before services are rendered (see the "Prior Authorization Program").

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.

Cigna has established a network of transplant facilities known as **Cigna LIFESOURCE Transplant Network® Facilities (Lifesource Facilities)** to provide services for specified organ tissue or bone marrow transplants, following a determination that a transplant is Medically Necessary and the insured qualifies for the transplant, including:

- heart
- liver
- lung
- heart/lung
- simultaneous pancreas/kidney
- pancreas
- bone marrow harvest and transplant, including autologous and allogenic bone marrow transplant
- peripheral stem cell transplant and similar procedures

Cigna will not deny coverage that is otherwise available under the Policy for the costs of solid organ or other tissue transplantation services based upon the insured being infected with HIV.

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 any other facilities, including Non-Participating Providers and Participating Providers contracted with Cigna for other services, but not for transplant services, are covered at the Out-of-Network benefit level.

Cigna LIFESOURCE Transplant Network® Facility Benefit Exclusions and Limitations

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

- Charges for any treatment, supply or device which is Experimental, Investigative or not a generally accepted medical practice.
- 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:

- outpatient Diabetes Self-Management Training,
- education and medical nutrition therapy,
- Diabetes Equipment and
- Diabetes Pharmaceuticals & Supplies for the treatment of Type I Diabetes, Type 2 Diabetes, and Gestational Diabetes Mellitus.

The following Diabetes Supplies are covered under the Prescription Drug Benefit:
Insulin;

- syringes;
- injection aids,
- blood glucose monitors,
- blood glucose monitors for the legally blind;
- glucose test strips;
- visual reading ketone strips;
- urine test strips;
- lancets;
- insulin pumps,
- infusion devices and accessories,
- oral hypoglycemic agents;
- Glucagon emergency kits and
- alcohol swabs.

Pediatric Asthma

This Policy provides benefits for Covered Expenses for pediatric asthma, including:

- Tests to diagnose and/or determine the severity of pediatric asthma;
- Treatment for pediatric asthma (prescription medications for treatment are covered under the Prescription Drug Benefits of this Policy);
- Ongoing medical monitoring of the symptoms, treatment and condition of an Insured Person diagnosed with pediatric asthma;
- Education for pediatric asthma, including education to enable an Insured Person to properly use a device prescribed for treatment.

Treatment Received from Foreign Country Providers

This Policy provides benefits for Covered Expenses for services and supplies received from Foreign Country Providers are covered 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 assignment of benefits from Foreign Country Providers. You and Your Dependent can file a claim with Cigna for services and supplies from a Foreign Country Provider but any payment will be sent to the Insured Person. The Insured Person is responsible for paying the 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

Services must be furnished by a Home Health Agency or a Visiting Nurses Association.

This 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 any combined maximum number of visits each Year as shown in the Benefit Schedule.**

Home Health Care services are provided for persons diagnosed as having any significant destruction of brain tissue with resultant loss of brain function (e.g. progressive, degenerative, and dementing illnesses such as Alzheimer's disease).

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 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. Coverage is provided for house calls by a Physician or registered nurse when care can best be provided in the home as determined by the Physician.
- Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association.
- Services of a medical social worker.
- Home Health Services include diagnostic and treatment services that can reasonably be provided in the home, including nursing care, performed by a registered nurse, public health nurse, licensed vocational nurse or licensed home health aide, and that home health services may also include such rehabilitation, physical, occupational or other therapy, as the Physician shall determine to be medically appropriate.

Note: The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less per visit by a nurse, medical social worker, PT/OT/ST and 3 hours per visit for a home health aid (e.g., maximum of 8 visits per day).

Coverage will not be provided for:

- Care that an unlicensed Dependent or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if We would cover the care if it were provided by a qualified medical professional in a Hospital or a Skilled Nursing Facility
- Care in the home if the home is not a safe and effective treatment setting

Mastectomy and Related Procedures

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 for the treatment of physical complications of all stages of mastectomy, including lymphedemas, whether or not the mastectomy occurred while the Insured Person was covered under this Policy.

Coverage is provided for screening and diagnosis of breast cancer, consistent with generally accepted medical practice and scientific evidence, upon the referral of the insured's Physician.

Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer or for a period of time determined by a Physician in consultation with the patient. If 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 TMJ (Temporomandibular Joint Dysfunction)

Medical services for TMJ are covered on the same basis as any other medical condition. 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 (except for Cleft Palate), including TMJ.

Cigna will cover surgical procedures for covered conditions directly affecting the upper or lower jawbone, or associated bone joints, if each procedure being considered for reimbursement is medically necessary.

Conditions Attributable to Diethylstilbestrol

Medical services for conditions attributable to diethylstilbestrol are paid on the same basis as any other medical condition.

Prosthetic Appliances following Laryngectomy

Benefits are payable for prosthetic appliances, including devices to restore a method of speaking following a laryngectomy, other than electronic voice-producing machines.

Phenylketonuria (PKU) Testing and Treatment

Benefits are payable for the testing and treatment of PKU. This includes Formulas and Special Food Products that are part of a diet prescribed by a Physician and managed by a health care professional in consultation with a Physician specializing in the treatment of metabolic diseases. The diet must be deemed Medically Necessary to avoid the development of serious mental or physical disabilities or to promote normal development or function resulting from PKU.

Smoking Cessation

This Policy provides benefits for Covered Expenses for Smoking Cessation Attempts, as defined in the Policy.

Off Label Drugs

A drug that has been prescribed for purposes other than those approved by the FDA will be covered if:

- the drug is otherwise approved by the FDA;
- the drug is used to treat a life-threatening condition or, a chronic and seriously debilitating condition and the drug is Medically Necessary to treat that condition;
- the drug has been recognized for the treatment prescribed by any of the following:
  - (A) the American Hospital Formulary Service Drug Information,
  - (B) one of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen;
    - (i) The Elsevier Gold Standard's Clinical Pharmacology;
    - (ii) The National Comprehensive Cancer Network Drug and Biologics compendium;
    - (iii) The Thomson Micromedix Drug Dex; or
  - (C) two articles from major peer reviewed medical journals that present data supporting the proposed use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

Medically Necessary Covered Services associated with the administration of the drug are subject to the conditions of the Policy.

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, 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 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.

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.

Cancer Clinical Trials

Benefits are payable for an Insured diagnosed with cancer and accepted into a phase I through IV clinical trial for cancer for all routine patient care costs related to the clinical trial if the Insured's treating Physician recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Insured.

The clinical trial must meet the following requirements:

- The trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.
- The treatment provided in a clinical trial must either be:
    1. Approved by the National Institutes of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the U.S. Veterans' Administration, or
    2. Involve a drug that is exempt under federal regulations from a new drug application.

Routine patient care costs are costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be covered by the Cigna if they were not provided in connection with a clinical trial, including the following:

- Services typically provided absent a clinical trial.
- Services required solely for the provision of the investigational drug, item, device or service.
- 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.
- Reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

If the clinical trial is conducted by a non-Participating Provider, the payment shall be at the negotiated rate that Cigna would otherwise pay to a Participating Provider for the same services, less any applicable Copayments and deductibles.

Cigna may restrict coverage for clinical trials to Participating Hospitals and Physicians in California, unless the protocol for the trial is not provided in California.

Second Opinions

You or Your Physician or Other Participating Health Professional may request a second opinion relating to a medical treatment or surgical procedure.

Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

(A) If you question the reasonableness or necessity of recommended surgical procedures.

(B) If you question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

(C) If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and you request an additional diagnosis.

(D) If the treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment.

(E) If you have attempted to follow the plan of care or consulted with your initial provider concerning serious concerns about the diagnosis or plan of care.

Telehealth Services

Telehealth Services means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, treatment, education, care management, and self-management of a patient's health care while the patient is at the Originating Site and the Provider for Telehealth is at a Distant Site. Telehealth facilitates patient self-management and caregiver support for patients and includes:

- Synchronous Interactions; Synchronous Interaction means a real-time interaction between a patient and a Health Care Provider for Telehealth located at a Distant Site; and
- Asychronous Store and Forward transfers; Asychronous Store and Forward means the transmission of a patient's medical information from an Originating Site to the Health Care Provider for Telehealth at a Distant Site without the presence of the patient.
- Originating Site means a site where a patient is located at the time health care services are provided via telecommunications system or where the Asynchronous Store and Forward service originates.
- Distant Site means a site where a Health Care Provider for Telehealth who provides health care services is located while providing these services via a telecommunications system.

Osteoporosis

Services provided in connection with the for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.

Bariatric Surgery

Bariatric surgery is surgery to treat obesity by modifying the gastrointestinal tract to reduce nutrient absorption is covered if Medically Necessary and if insured completes pre-surgical education program.

Covers transportation and hotel accommodations if insured lives more than 50 miles from facility where referred. Transportation and hotel accommodations also covered for one companion as well.

Coverage for the surgery includes Hospital inpatient care (room and board, imaging, laboratory, special procedures, and Physician services).

Services Covered Under Prescription Drug Benefits

Injectable drugs (self-injectable medications) **that do not require Physician supervision; 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, and **Self-administered Injectable Drugs**, (refer to the “Prescription Drug Benefits”).

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:

1. Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
2. Services or supplies that are not Medically Necessary, except for voluntary family planning and preventive care services or treatment**.**
3. Services or supplies for **Experimental Procedures or Investigative Procedures**.
4. Services received **before the Effective Date** of coverage.
5. Services received **after coverage under this Policy ends**.
6. 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.
7. 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.
8. 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.
9. 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.
10. Professional **services or supplies received or purchased directly or on Your behalf by anyone, including a Physician from** any of the following:
    a. Yourself or Your employer;
    b. a person who lives in the Insured Person's home, or that person's employer;
    c. a person who is related to the Insured Person by blood, marriage or adoption, or that person's employer.
11. **Physical exams** and other services required on court order or required for parole or probation. This exclusion does not apply to medically necessary services.
12. **Assistance with activities of daily living** (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine). This exclusion does not apply to assistance with activities of daily living that is provided as part of covered Hospice, Skilled Nursing Facility, or inpatient Hospital care.
13. Inpatient or outpatient services of a **private duty nurse.** Cigna excludes private duty nursing for the following reasons: a) When an Insured Person is confined to a Hospital or other covered facility, the facility provides 24-hour nursing care, b) When an Insured Person is home and requires nursing care, licensed nurses are covered to provide Home Health Care benefits. In-home private duty nursing includes care that is not covered, such as assistance with activities of daily living, and an Insured Person who requires 24-hour nursing care is normally admitted to a facility appropriate to the level of care required.

14. Inpatient room and board **charges in connection with a Hospital stay primarily for diagnostic tests** which could have been performed on an outpatient basis, unless the Hospital stay is Medically Necessary.
15. **Dental services for adults age 19 and over**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as otherwise stated in this Policy under “Dental Care”.
16. **Orthodontic Services for adults age 19 and over**, 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.
17. **Dental Implants for adults age 19 and over** 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.
18. **Hearing aids** except for internally-implanted devices.. A hearing aid is any device that amplifies sound.
19. **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, , and eye exams for refraction for adults age 19 and over.
20. An **eye surgery** for Insured Persons age 19 and above solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
21. **Cosmetic Services**: Services that are intended primarily to change or maintain one’s appearance. The exclusion shall not apply to any of the following: Reconstructive Surgery (Please see page 19: “Definitions – Cosmetic and Reconstructive Surgery”) or Mastectomy (Please see page 60: “Mastectomy and Related Procedures”); Durable Medical Equipment, Prosthetics, and Orthotic devices incident to a reconstructive surgery or mastectomy, including testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part.
22. **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.
23. **Non-Medical counseling or ancillary services**, including but not limited to: education, training, vocational rehabilitation, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety.
24. **Gender/sex reassignment surgery** is not covered unless the health care services involved are otherwise available under the policy. This exclusion does not permit the denial of coverage if the health care services involved are otherwise available under the policy, including but not limited to hormone therapy, hysterectomy, mastectomy, and vocal training. Also, this exclusion does not permit the denial of coverage for health care services available to a covered person of one sex due only to the fact that the covered person is enrolled as belonging to the other sex or has undergone, or is in the process of undergoing, a gender transition.
25. 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.

26. **Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision,** if not provided by a Participating Provider.
27. 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.
28. **Cryopreservation** of sperm or eggs.
29. 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.
30. **Orthopedic shoes** (except when joined to braces) or shoe inserts, including orthotics except for diabetic shoes and inserts, including off-the-shelf depth-inlay shoes, custom-molded shoes, custom-molded multiple density inserts, fitting, modification, and follow-up care for podiatric devices. Coverage will include fitting and adjustment, repair or replacement (but not for loss or misuse), and services to determine whether an insured needs a prosthetic or orthotic device.
31. **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.
32. 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.).
33. Services primarily for **weight reduction** or treatment of obesity except morbid obesity, or any care which involves weight reduction as a main method for treatment.
34. **Educational services** except for Bariatric surgery related health education, health education for tobacco cessation and stress management, chemical dependency and substance use disorder, preventive dental, post-natal, preventive health, Diabetes Self-Management Training Program, Pediatric Asthma Training, and as specifically provided or arranged by Cigna.
35. **Outpatient oral nutrition**, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food.
36. **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: shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; correction appliances or support appliances and supplies such as stockings, disposable supplies as follows: Bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies. This exclusion shall not apply to disposable supplies covered as "Durable Medical Equipment," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Prescription Drug Benefits".
37. All **Foreign Country Provider charges** other than emergency or urgent care services.
38. **Growth Hormone Treatment,** except when such treatment is Medically Necessary 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 Medically Necessary and

effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition.

39. **Routine foot care**, such as nail clipping or corn removal that is not Medically Necessary.
40. **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.
41. **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 has been satisfied, subject to any applicable Copay 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 "brand-name" 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.

Pharmacy Deductible means the Additional Deductible that an Insured Person or a Family must meet each Year before We will begin paying Covered Expenses for Prescription drugs. This Additional Deductible is separate from Deductibles that apply to medical services but does accumulate toward satisfying the medical Out- of-Pocket Maximum(s).

Covered Expenses

If the Insured Person(s), while covered under this Policy, 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

- All Medically Necessary Outpatient Drugs and medications that Federal and/or State of California law restrict to sale by Prescription only (except for insulin, which does not require a Prescription).
- Medically Necessary Diabetic supplies (Insulin needles and syringes; lancets and glucose test stripes), needles and syringes for self-injectible outpatient prescription drugs that are not

dispensed in pre-filled syringes. Injection aids, blood glucose monitors, blood glucose monitors for the legally blind; visual reading ketone strips; urine test strips; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.

- Orally administered anti-cancer medications prescribed in connection with cancer chemotherapy treatments. The total amount of Coinsurance You pay for each Prescription Order of up to a 30 day supply is limited to $200, after any applicable Deductible.
- 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. A drug that has been prescribed for purposes other than those approved by the FDA will be covered if:

  a) the drug is used to treat a life-threatening condition or, a chronic and seriously debilitating condition and the drug is Medically Necessary to treat that condition;

  (b) the drug has been recognized for the treatment prescribed by either the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, the U.S. Pharmacopeia Dispensing Information, or two articles from major peer reviewed medical journals that are not contradicted by another such article; and

  (c) the drug is otherwise approved by the FDA.

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.

Coverage for replacements, in the event of breakage, loss, or loss of function of, inhaler spacers, and peak flow meters when Medically Necessary to maintain compliance with the Insured Person's treatment regimen.

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 service program.
- The Drug or medicine must not be used while the Insured Person is an inpatient in any facility.
- The Prescription must not exceed days' supply indicated in the "Limitations" section below.
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification.

Services Covered Under Medical Benefits

- Drugs administered in a Physician's office
- 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.

Exclusions

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

a. Drugs not approved by the Food and Drug Administration (FDA);

b. Drugs available over the counter that do not require a prescription by federal or state law, except for FDA approved female contraceptive methods available over-the-counter which are prescribed by a health care provider per the Health Resources and Services Administration Women's Preventive Services Guidelines, or drugs available over the counter with a US Preventive Services Task Force (USPSTF) recommendation of A or B;

c. Drugs that do not require a Federal legend (a Federal designation for drugs requiring supervision of a Physician), other than insulin;

d. Any infusion or injectable specialty prescription drugs if not provided by a Participating Pharmacy;

e. Injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs are covered under the medical benefits of this Plan and require Prior Authorization. The following are examples of Physician supervised drugs: injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;

f. Infertility related drugs, except those required by the Patient Protection and Affordable Care Act (PPACA);

g. 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";

h. Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies; except for those pertaining to Diabetic Supplies and Equipment;

i. Prescription vitamins other than prenatal vitamins; dietary supplements, herbal supplements and flouride other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);

j. 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;

k. Medications used for travel prophylaxis, except anti-malarial drugs and drugs on the U.S. Preventive Service Task Force's (USPSTF) A or B recommended list, or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

l. Implantable contraceptive products inserted by the Physician are covered under the Plan's medical benefits;

m. 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 or idiopathic short stature, or improved athletic performance is not covered under any circumstances.;

n. Drugs obtained outside the United States;

o. Replacement of Prescription Drugs and Related Supplies due to loss or theft;

p. 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;

q. Prescription Expiration date: Prescriptions for a Non-Controlled substance that are written by a licensed healthcare professional that are over one (1) year from the date written are excluded from coverage. Prescriptions for a Controlled substance written by a licensed healthcare professional that are over six (6) months from the date written are excluded from coverage.

Limitations

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

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

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.

Prescription contraceptives are subject to different cost sharing rules. Cigna's Prescription Drug List covers at least one therapeutic equivalent contraceptive service or item within each of the contraceptive methods (currently 18) identified by the FDA for women without cost sharing. Additionally, if an Insured Person's Provider recommends a particular service or FDA-approved item based on a determination of Medical Necessity made by the Provider with respect to that individual, Cigna will cover that service or item without cost sharing. Cigna will defer to the determination of the Provider with regard to Medical Necessity, and approve coverage without cost sharing within two days of a prior authorization request made by a Provider.

In the event that You or Your Physician requests 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 "brand name" Copayment Or Coinsurance shown in the Benefit Schedule.

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

Pharmacy Formulary Exception Process/Prior Authorization for Retail and Mail Order Pharmacies

The presence of Prescription Drugs and Related Supplies on the Prescription Drug List does not guarantee that the Insured Person will be prescribed that Prescription Drug and Related Supplies by his/her Participating Physician for a particular medical condition.

You may contact Member Services at the toll-free number found on Your Cigna HealthCare ID card to request a copy of the Prescription Drug List or to request information regarding whether a specific drug or drugs are on the Prescription Drug List. You can also access the Prescription Drug List through the Internet at www.cigna.com/ifp-drug-list.

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. Cigna shall also maintain an expeditious process by which Participating Providers may obtain authorization for Medically Necessary non-Prescription Drug List Drugs and Related Supplies. If Your Physician reasonably believes that there is a Medically Necessary reason to prescribe a non-Prescription Drug List Drug and/or Related Supplies, or wishes to request coverage for a Prescription Drug and/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 obtain the Prior Authorization form at https://cignaforhcp.cigna.com or by calling the Cigna customer service number on the back of the member's ID card. The Physician should make this request before writing the prescription.

If the Insured Person is advised at the Pharmacy that the prescription is for a non-Prescription Drug List Drug and/or Related Supplies and the Physician has not contacted Cigna for authorization, the Pharmacy will dispense the Prescription Drug and/or Related Supplies at the full retail cost of the non-Prescription Drug List drug. The Insured Person may request that the Pharmacy contact the Insured Person's Physician to request a change to a Prescription Drug List medication or submit a request to Cigna for coverage of the non-Prescription Drug List Drug and/or Related Supplies as Medically Necessary. If the Insured Person's Physician is not available or the Pharmacy is not able to reach Cigna all Pharmacies have been instructed to dispense at least a three (3) day supply, but not more than a thirty (30) day supply at the applicable Copayment/Coinsurance. If after being contacted the Insured Person's Physician reasonably believes a change to a Prescription Drug List Drug and/or Related Supplies is appropriate, Cigna will notify both the Insured Person and the Participating Pharmacy. If after consultation with the Insured Person's Physician, the non-Prescription Drug List Drug and/or Related Supplies is approved as Medically Necessary, the Insured Person will continue to receive the non-prescription Drug List Drug and/or Related Supplies at the applicable Copayment/Coinsurance.

If the request for approval involves a Medically Necessary new non-Prescription Drug List Drug and/or Related Supplies or a refill non-Prescription Drug List Drug and/or Related Supplies where the Insured Person has no more of the Prescription Drug and/or Related Supplies, Cigna will make a decision and communicate it to all parties by telephone on the same day as receipt of the request from the Insured Person's Physician but in any event not more than twenty-four (24) hours from the time of receipt. Requests for refills where the Insured Person has more of the drug remaining will

be made and communicated in writing to all parties within forty-eight (48) hours from the time of receipt of the request from the Insured Person's Physician.

The length of the authorization will depend on the diagnosis and the Prescription Drug and/or Related Supplies. If the request is denied, Your Physician and You will be notified that coverage for the Prescription Drugs and/or Related Supplies is not authorized.

Cigna shall not limit or exclude coverage for a Prescription Drug and/or Related Supplies for an Insured Person if the drug had previously been approved for coverage by Cigna for a medical condition of the Insured Person and the Insured Person's Physician continues to Prescribe the drug for the medical condition provided that the drug is appropriately prescribed, and is considered safe and effective for treating the Insured Person's medical condition. Nothing shall preclude the Physician from prescribing another drug, including a "generic" drug covered by Cigna that is medically appropriate for the Member. This section does not apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA).

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

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 Exception Request

You or Your Physician can submit a request for Cigna to make an exception and cover clinically appropriate Drugs not otherwise covered by this Plan. This is called a request for exception. In the event that an exception request is granted, the Cigna must treat the excepted drug(s) as an essential health benefit.

Standard Exception Request
Your Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request a standard review of a decision that a Drug is not covered by the Plan. The Physician can obtain the Prior Authorization form at https://cignaforhcp.cigna.com or by calling the Cigna customer service number on the back of the Insured Person's ID card. The Physician should make this request before writing the prescription.

Cigna must make a determination on the standard exception request and notify the You or the prescribing Physician of its coverage determination no later than 72 hours following receipt of the request.

When Cigna grants a standard exception request, We will provide coverage of the non-formulary drug for the duration of the prescription, including refills.

Expedited Exception Request

You or Your Physician can request an expedited review based on exigent circumstances. Exigent circumstances exist when You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function or when You are undergoing a current course of treatment using a non-formulary drug.

Cigna must make its coverage determination on an expedited review request based on exigent circumstances and notify You and the prescribing Physician of its coverage determination no later than 24 hours following receipt of the request.

When Cigna grants an exception based on exigent circumstances, We will provide coverage of the non-formulary drug for the duration of the exigency.

External Prescription Request Review
If Cigna denies a request for a standard exception or for an expedited exception, You or the prescribing Physician can request that the original exception request and subsequent denial of such request be reviewed by an independent review organization.

Cigna must make its determination on the external exception request and notify You and the prescribing Physician of its coverage determination no later than 72 hours following its receipt of a standard exception request, and no later than 24 hours following its receipt of an expedited exception request.

If Cigna grants an external exception review of a standard exception request, We must provide coverage of the non-formulary drug for the duration of the prescription. If Cigna grants an external exception review of an expedited exception request, We must provide coverage of the non-formulary drug for the duration of the exigency.

Pain Management Medications

Appropriately prescribed pain management medications for terminally ill patients when Medically Necessary shall be approved or denied for an Insured Person who has been determined to be terminally ill in a timely fashion, appropriate for the nature of the Insured Person's condition, not to exceed 72 hours of Cigna’s receipt of the information requested to make the decision. If the request is denied or if additional information is required, Cigna shall contact the Physician within one working day of the determination, with an explanation of the reason for the denial or the need for additional information. The requested treatment shall be deemed authorized as of the expiration of the applicable timeframe. The Physician shall contact Cigna within one business day of proceeding with the deemed authorized treatment, to do all of the following:

(1) Confirm that the timeframe has expired.

(2) Provide enrollee identification.

(3) Notify the plan of the provider or providers performing the treatment.

(4) Notify the plan of the facility or location where the treatment was rendered.

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 purchases 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.

Claims and Customer Service

Drug claim forms for Non-Participating Pharmacies are available upon written request to:

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

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

Forms are also available online at myCigna.com.

If You or Your Dependent(s) 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

Please be aware that the Pediatric Vision network is different from the network of your medical benefits. Benefits for lenses and frames are not payable for non-network Vision Care providers.

Pediatric Vision Benefit Schedule

BENEFIT INFORMATION **Note:** **Covered Services are subject to applicable Deductible unless specifically waived.**	**IN-NETWORK – WHAT YOU PAY (Based on Cigna contract allowance)** **THE AMOUNTS SHOWN BELOW ARE WHAT YOU PAY Including the amount of Deductible, Copayments, and the Coinsurance amount You pay after Deductible has been met.**	**OUT-OF-NETWORK – WHAT YOU PAY (Based on Maximum Reimbursable Charge)**
Pediatric Vision Care Performed by an Ophthalmologist or Optometrist* for Insured Persons up to 19 years of age. *Please be aware that the Pediatric Vision network is different from the network of your medical benefits		
Comprehensive Eye Exam for Children Limited to one exam per Calendar Year	$0 per exam, Deductible waived	50% of charges
Eyeglasses and Lenses for Children Single Vision, Lined Bifocal Lined Trifocal Lenticular. Limited to one pair per Calendar Year	$0 per pair, Deductible waived	Not Covered
Pediatric Frame Collection Limited to one per Calendar Year	$0 per pair, Deductible waived	Not Covered
Elective and Therapeutic Contact Lenses and Professional Services Limited to 12 month supply per Calendar Year	$0 per pair, Deductible waived	Not Covered
Low Vision One comprehensive low vision evaluation,including one follow-up care visit and onelow vision aid, annually	$0, Deductible waived	Not Covered

What Is Covered

In-Network Covered Benefits for Insured Persons less than 19 years of age include:

- **Examinations** – One vision and eye health evaluation by an Optometrist or an Ophthalmologist 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).

Single vision; conventional (lined) bifocal and trifocal; lenticular; glass, plastic, and polycarbonate lens materials; all lens powers; fashion and gradient tinting; oversized and glass-grey #3 prescription sunglass lenses; scratch resistant coating; ultraviolet protective coating; blended segment lenses; intermediate vision lenses; standard, premium, select, and ultra progressive lenses; photochromatic glass lenses; plastic photosensitive lenses; polarized lenses; standard, premium, and ultra anti-reflective coating; high-index lenses.

Elective and Therapeutic Contact Lenses – A 12 month supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens coverage includes charges for contact lens evaluation, fitting, and follow-up care (separate from the routine eye exam).

- Coverage for **Therapeutic contact lenses** – In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism.
- **Frames** – One frame for prescription lenses from Pediatric Frame Collection. Only frames in the Pediatric Frame Collection are covered at 100%. Non-collection frames are available at 75% of retail.
- **Low Vision Coverage**: One comprehensive low vision evaluation, including one follow-up care visit and one low vision aid, annually, 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 high-power spectacles, magnifiers, and telescopes, which can aid the Insured Person with their specific needs. Some Cigna Vision Network Eye Care Professionals may not offer these services. Please check with your eye care professional first before scheduling an appointment.
- Visual therapy, including orthoptic or vision training, for the purposes of rehabilitative or habilitative treatment.

.*Exclusions*

a) Any **eye examination, or any corrective eyewear**, required by an employer as a condition of employment.

b) Charges **incurred after the Policy ends** or the Insured's coverage under the Policy ends, except as stated in the Policy.

c) **Experimental** or non-conventional treatment or device.

d) Any **non-prescription** eyeglasses, lenses, or contact lenses.

e) **Spectacle lens treatments**, "add ons", or lens coatings not otherwise listed in "What's Covered" within this section.

f) **Two pair of glasses**, in lieu of bifocals or trifocals.

g) **Safety glasses** or lenses required for employment.

h) **VDT** (video display terminal)/computer eyeglass benefit.

i) For or in connection with **experimental procedures or treatment methods** not approved by the American Medical Association or the appropriate vision specialty society.

j) Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.

Limitations

No payment will be made 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.

No payment will be made for expenses incurred for:

- other Exclusions and Limitations listed in this Policy, lenses which are not medically necessary and are not prescribed by an Optometrist or Ophthalmologist, or frames for such lenses;
- care not listed in the benefit schedule.

In addition, these benefits will be reduced so that the total payment 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.

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
Claim Department
P.O. Box 385018
Birmingham, AL 35238-5018

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

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

Pediatric Dental Benefits

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to the age of 19.

The Policy sets forth, in more detail, the rights and obligations of both You, your Dependent(s) and Cigna. It is, therefore, important that all Insured Persons **READ THE ENTIRE POLICY SECTION CAREFULLY!**

The benefits outlined in the table below show the payment percentages for Covered Expenses **AFTER** any applicable Deductibles have been satisfied unless otherwise stated.

If you select a Participating Provider, your cost will be less than if you select a Non-Participating Provider.

The Benefit Percentage payable for Emergency Services charges made by a Non-Participating Provider is the same Benefit Percentage as for Participating Provider Charges. An emergency is a dental condition, including severe pain, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the Member's health in serious jeopardy;
- Causing serious impairment to the Member's dental functions; or
- Causing serious dysfunction of any of the Member's bodily organs or parts.

Pediatric Dental Deductible

Deductible means the amount of pediatric dental Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

Dental PPO – Participating and Non-Participating Providers

Participating Provider services are paid based on the Contracted Fee that is agreed to by the provider and Cigna. Based on the provider's Contracted Fee, a higher level of plan payment may be made to a Participating Provider resulting in a lower payment responsibility for you. To determine how your Participating Provider compares refer to your provider directory. Provider information may change annually; refer to your provider directory prior to receiving a service. You have access to a list of all providers who participate in the network by visiting www.mycigna.

Plan payment for a covered service delivered by a Cigna DPPO Advantage Participating Provider is the Contracted Fee for that procedure, times the benefit percentage that applies to the class of service, as specified in the Schedule.

The covered person is responsible for the balance of the Contracted Fee.

Plan payment for a covered service delivered by a Cigna DPPO Participating Provider is the lesser of the Contracted Fee or the Maximum Allowable Charge. The Maximum Allowable Charge is the fee for that procedure as listed on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, times the benefit percentage that applies to the class of service, as specified in the Schedule. The Primary Schedule is the fee schedule with the

lowest Contracted Fees currently being accepted by a Participating Provider in the relevant 3-digit zip code.

The covered person is responsible for the Cigna DPPO Participating Provider Contracted Fee minus what the plan pays.

Plan payment for a covered service delivered by a non-Participating Provider is the lesser of the non-Participating Provider's actual charge or the Maximum Allowable Charge. The Maximum Allowable Charge is the fee for that procedure as listed on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, times the benefit percentage that applies to the class of service, as specified in the Schedule. The Primary Schedule is the fee schedule with the lowest Contracted Fees currently being accepted by a Participating Provider in the relevant 3-digit zip code.

The covered person is responsible for the non-Participating Provider's actual charge minus what the plan pays.

Dental Benefit Schedule:

	Cigna DPPO Advantage Participating Providers	**Cigna DPPO Participating Providers* and Non–Participating Providers**
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class II, III & IV	Combined with Medical	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	Combined with Medical	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
Class I - Preventive/Diagnostic Services	100%	100%
Class II - Basic Restorative Services	80%	80%
Class III - Major Restorative Services	50%	50%
Class IV – Medically Necessary Orthodontia	50%	50%

***If you choose to visit a Cigna DPPO provider, you will receive a discounted rate. For the greatest potential savings, please see a Cigna DPPO Advantage provider.**

Covered Dental Expenses

The following section lists covered dental services; if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS	
Clinical oral evaluation except detailed and extensive oral evaluation, problem focused, by report.	
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)	
Complete mouth survey or panoramic x-rays	1 complete mouth series or panoramic x ray in any 24 consecutive month period. Full mouth series includes bitewings and 10 or more periapical x-rays.
Bitewing x-rays	Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)	
TESTS AND EXAMINATIONS	
Pulp Vitality Tests	
DENTAL PROPHYLAXIS (Cleaning)	
Prophylaxis (cleaning)	2 per year. More frequent Cleanings may be approved if Medically necessary
FLOURIDE TREATMENT	
Topical application of Fluoride	1 per 6 month period
OTHER PREVENTIVE SERVICES	
Sealant-per tooth	Permanent First and Second molars only
Nutritional counseling for control of dental disease	
Tobacco counseling for the control and prevention of oral disease	
Oral hygiene instructions (and Preventive Dental Education)	
SPACE MAINTENANCE (PASSIVE APPLIANCES)	
Space maintainers	Nonorthodontic treatment for prematurely removed or missing teeth.
Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT	
Emergency Treatment including palliative treatment	
PERSONAL CONSULTATION	

Consultation (including specialist consultations)	

Class II – Basic restorative services

Fillings	
Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries; Micro filled resin restorations which are non-cosmetic; Replacement of a restoration; pins and pin build-up in conjunction with a restoration Composite Restorations	Silver and Tooth-colored restoration required
OTHER RESTORATIVE SERVICES	
Recement inlay, onlay, or partial coverage restoration	
Recement cast or prefabricated post and core	
Recement crown (and bridges)	
Pin retention - per tooth, in addition to restoration	Covered only in conjunction with amalgam or composite restoration. Payable one time per restoration regardless of the number of pins used
Sedative base and sedative fillings	
PULP CAPPING	
Pulp cap – direct or indirect (excluding final restoration)	
PULPOTOMY	
Therapeutic / Vital pulpotomy (excluding final restoration)	
APEXIFICATION/RECALCIFICATION PROCEDURES	
Apexification/recalcification (calcium hydroxide)	Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. A maximum of 3 visits per tooth are payable.
Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES	
Apicoectomy/periradicular surgery	Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.
Root amputation - per root	Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.
NON-SURGICAL PERIODONTAL SERVICE	

Gingivectomy or gingivoplasty	
Gingival flap procedure (subgingival curettage), including root planing	5 quadrant treatment in any 12 consecutive month period
Osseous or mucogingival surgery (including flap entry and closure)	
Periodontal scaling and root planing	5 quadrant treatment in any 12 consecutive month period
Emergency treatment including treatment for periodontal abscess or periodontitis	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)	
Extraction, coronal remnants - deciduous tooth	Includes post-operative services (including exams), suture removal and treatment of complications
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Includes post-operative services (including exams), suture removal and treatment of complications
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Includes post-operative services (including exams), suture removal and treatment of complications
Removal of impacted tooth	Removal of impacted teeth limited as follows: surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists. Includes post-operative services (including exams), suture removal and treatment of complications
Surgical removal of residual tooth roots (cutting procedure)	Removal of impacted teeth limited as follows: surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists. Includes post-operative services (including exams), suture removal and treatment of complications
Root recovery (separate procedure)	
OTHER SURGICAL PROCEDURES	
Biopsy of oral tissue including brush biopsy technique	Includes post-operative services (including exams), suture removal and treatment of complications
ALVEOLOPLASTY/ALVEOLOECTOMY - SURGICAL PREPARATION OF RIDGE FOR DENTURES	
Alveoloplasty /alveoloectomy	Includes post-operative services (including exams), suture removal and treatment of complications
SURGICAL EXCISION OF SOFT TISSUE LESIONS	
Excision of benign lesion	Includes post-operative services (including exams), suture removal and treatment of complications
Excision of malignant lesion	Covered if Cancer Related. Includes post-operative services (including exams), suture removal and treatment of complications
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS	
Excision of malignant tumor	Covered if Cancer Related. Includes post-operative services (including exams), suture removal and treatment of complications

Removal of benign odontogenic cyst, neoplasms, or tumor -	Includes post-operative services (including exams), suture removal and treatment of complications
EXCISION OF BONE TISSUE	
Removal of lateral exostosis (maxilla or mandible)	Includes post-operative services (including exams), suture removal and treatment of complications
Removal of torus palatinus	Includes post-operative services (including exams), suture removal and treatment of complications
Removal of torus mandibularis	Includes post-operative services (including exams), suture removal and treatment of complications
SURGICAL INCISION	
Incision and drainage of abscess	Includes post-operative services (including exams), suture removal and treatment of complications
TREATMENT OF FRACTURES	
Open or closed reduction	
Malar and/or zygomatic arch open or closed reduction	
Alveolus – open or closed reduction, may include stabilization of teeth	
Facial bones - complicated reduction with fixation and multiple surgical approaches	
OTHER REPAIR PROCEDURES	
Frenulectomy (frenectomy or frenotomy) - separate procedure	
REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS.	
Occlusal orthotic device	**Requires Pre-Authorization**
ANESTHESIA	
Local anesthesia	
Regional block anesthesia	
Trigeminal division block anesthesia	
Analgesia, anxiolysis, inhalation of nitrous oxideLocal anesthetics; Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of licensure; Nitrous Oxide when dispensed in a dental office by a practitioner acting within the scope of licensure.	
Non-intravenous conscious sedation	

Class III – Major restorative services

CLINICAL ORAL EVALUATIONS	
Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS	

Inlays and Onlays	Covered only when the tooth cannot be restored by an amalgam or composite filling due to major decay or fracture, and then only if more than 84 months have elapsed since the last placement.
CROWNS AND FIXED BRIDGES	
Stainless Steel Crowns, Resin Crowns	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 per tooth in any consecutive 36-month period or if Medically necessary. Allowable for persons under 12 years of age.
Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown.	1 per tooth per 36 consecutive month period or except when the crown is no longer functional. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold; Recementation of crowns, bridges, inlays and onlays; Cast post and core, including cast retention under crowns; Repair or replacement of crowns, abutments or pontics..	
Related dowel pins and pin build-up	Cast post and core, including cast retention under crowns
OTHER RESTORATIVE SERVICES	
Core buildup, including any pins	Covered only in conjunction with amalgam or composite restoration. Payable one time per restoration regardless of the number of pins used
Cast post and core in addition to crown	Covered only for endodontically treated teeth with total loss of tooth structure
Prefabricated post and core in addition to crown	Covered only for endodontically treated teeth with total loss of tooth structure
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)	
Root Canal Therapy, Culture Canal	
ENDODONTIC RETREATMENT	
Retreatment of previous root canal therapy	Retreatment of root canals (including culture canal) is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology is not a covered benefit.
DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)	

Complete Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers; Office or laboratory relines or rebases; Denture repair; Denture adjustment; Tissue conditioning; Denture duplication; Stayplates	Dentures will not be replaced within thirty-six (36) consecutive months, unless: 1. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; or 2. The denture is unsatisfactory and cannot be made satisfactory. Full upper and/or lower dentures are not to be replaced within thirty-six (36) consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges. Office or laboratory relines or rebases are limited to one (1) per arch in any twelve (12) consecutive months. Tissue conditioning is limited to two (2) per denture. Implants are considered an optional benefit. Stayplates are a benefit only when used as anterior space maintainers for children
Partial dentures	Implants are considered an optional benefit. Stayplates are a benefit only when used as anterior space maintainers for children
ANESTHESIA	
Deep sedation/general anesthesia	Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure. General anesthesia and intravenous/conscious sedation given by a dentist for covered oral surgery. General anesthesia including intravenous/conscious sedation and associated facility charges and outpatient services in connection with dental procedures.
PROFESSIONAL VISIT	
House/extended care facility call	If dentist makes an emergency visit to a person in a hospital and performs no dental services.
Hospital call	If dentist makes an emergency visit to a person in a hospital and performs no dental services.

Class IV – Medically Necessary Orthodontia

For further information please see "Orthodontic Treatment" within the definition section of this Policy.

LIMITED ORTHODONTIC TREATMENT	
Limited, interceptive or comprehensive orthodontic treatment of the primary, transitional, adolescent or adult dentition	when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions
MINOR TREATMENT TO CONTROL HARMFUL HABITS	
Removable appliance therapy	when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions
Fixed appliance therapy	when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions
OTHER ORTHODONTIC SERVICES	
Pre-orthodontic treatment visit	

Periodic orthodontic treatment visit (as part of contract)	
Orthodontic retention (removal of appliances, construction and placement of retainer(s))	when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions
Orthodontic Treatment (alternative billing to a contract fee)	when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions
INTERCEPTIVE ORTHODONTIC TREATMENT	
Interceptive orthodontic treatment of the primary dentition	when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions
Interceptive orthodontic treatment of the transitional dentition	when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions
COMPREHENSIVE ORTHODONTIC TREATMENT	
Comprehensive orthodontic treatment of the transitional dentition	when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions
Comprehensive orthodontic treatment of the adolescent dentition	when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions
Comprehensive orthodontic treatment of the adult dentition	when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions
MINOR TREATMENT TO CONTROL HARMFUL HABITS	
Removable appliance therapy	when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions
Fixed appliance therapy	when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions
OTHER ORTHODONTIC SERVICES	
Pre-orthodontic treatment visit	
Periodic orthodontic treatment visit (as part of contract)	
Orthodontic retention (removal of appliances, construction and placement of retainer(s))	when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions
Orthodontic Treatment (alternative billing to a contract fee)	when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions

Definitions

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

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

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 charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee. The term Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services performed on an Insured Person, according to the Insured Person's dental benefit plan.

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 Contracted Fee 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 Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

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

Dentist The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the dental services described in the policy.

Effective Date is the date on which coverage under this Policy begins for You and any of Your Dependent(s).

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

Full-Time Student is a student enrolled at an accredited college, university or trade school and attending classes, carrying at least 12 units per term.

Functioning Natural Tooth means a Natural Tooth which is performing its normal role in the mastication (i.e., chewing) process in the covered person's upper or lower arch and which is opposed in the covered person's other arch by another natural tooth or prosthetic (i.e., artificial) replacement.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food.

Insured Means the applicant who has applied for, been accepted for coverage, and who is named as the Insured on the specification page.

Insured Person means both You, the applicant, and all other Dependent(s) who are covered under this 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 and/or Dentally Necessary Services provided by a Dentist or physician are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) health benefits for pediatric oral care

1. dental and orthodontic benefits covered by the benchmark plan
2. dental benefits covered by the Healthy Families Program
3. orthodontic benefits when medically necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions

(5) the most fitting level or service which can safely be given to you or your Dependent.

1. diagnosis,
2. treatment and
3. service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development for the body (i.e., not manufactured). Organic portions of a tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp (nerve).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care..

Newborn is an infant within 31 days of birth.

Orthodontic Treatment means Orthodontic procedures are a benefit only when the member has a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.

The six automatic qualifying conditions are as follows:

1) Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
2) craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
3) a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,

4) a cross-bite of individual anterior teeth causing destruction of soft tissue,

5) an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,

6) a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

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

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

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 on the specification page.

Covered Dental Expense: What the Policy Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Dependent(s) 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 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.

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule has been met;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment.

If the covered person requests or accepts a more costly covered service the service will be considered optional, and he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, Cigna will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $500.

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Exclusions and Limitations: What Is Not Covered By Pediatric Dental Benefits

Covered Expenses do not include expenses incurred for:

a) services that would be covered under this medical plan.

b) procedures which are not dentally necessary.

c) procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.

d) any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.

e) replacement of lost or stolen appliances.

f) replacement of teeth beyond the normal complement of 32.

g) prescription drugs.

h) any procedure, service, supply or appliance used primarily for the purpose of splinting.

i) orthodontic treatment. Except in cases where it is Dentally Necessary.

j) charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.

k) charges for travel time; transportation costs; or professional advice given on the phone.

l) temporary, transitional or interim dental services.

m) any charge for any treatment performed outside of the United States other than for Emergency Treatment.

n) oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party.

o) any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.

p) services for which benefits are not payable according to the "General Limitations" section.

q) for services or supplies that are not Dentally Necessary.

r) for services received before the Effective Date of coverage.

s) for services received after coverage under this Policy ends.

t) for services for which You have no legal obligation to pay or for which no charge would be made if You did not have dental insurance coverage.

u) for Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Dentist, 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.

v) for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition.

w) services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.

x) to the extent that payment is unlawful where the person resides when the expenses are incurred.

y) for charges which the person is not legally required to pay.

z) for charges which would not have been made if the person had no insurance.

aa) to the extent that billed charges exceed the rate of reimbursement as described in the Schedule.

bb) for charges for unnecessary care, treatment or surgery.

cc) to the extent that you or any of your Dependents is in any way paid for those expenses by or through a public program, other than Medicaid.

dd) for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

ee) to the extent that benefits are paid for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna will take into account any adjustment option chosen under such part by you or any one of your Dependents.

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.

Insurance with Other Insurers

If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for the proportion of the loss as the amount which would otherwise have been payable under this policy plus the total of the like amounts under all the other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for the loss, and for the return of the portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of the other coverage shall be taken as the amount which the services rendered would have cost in the absence of the coverage.

Medicare Eligibles

Cigna will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

- an Insured Person who is eligible for Medicare for any reason other than End Stage Renal Disease; or
- an Insured Person who is eligible for Medicare due to End Stage Renal Disease, after that person has been eligible for Medicare for 30 months;

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 of Medicare without premium payment, but did not apply,
- An Insured Person who is entitled to enroll in Part B of Medicare, but is not enrolled.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare

could become effective for him.

- This reduction will not apply to any Insured Person except as listed under “Cigna will pay as the Secondary Plan…” above.

Alternate Cost Containment Provision

We may, in certain situations, approve services under an alternate treatment plan. An alternate treatment plan may include services or supplies otherwise limited or excluded by the 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.

WHEN YOU HAVE A COMPLAINT 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 Customer Service

If you have a concern regarding a person, a service, the quality of care, contractual benefits, an initial eligibility denial or a rescission of coverage, You can call our toll-free number and explain Your concern to one of Our Customer Service representatives.

Please call Us at the Customer Services Toll-Free Number that appears on Your Benefit Identification card, your explanation of benefits, or claim form.

We will do our best to resolve the matter on Your initial contact with Customer Service. If We need more time to review or investigate Your concern, We will get back to You as soon as possible, but in no more than 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.

Independent Review Process for Experimental and Investigational Therapies

Special provisions apply to the IMR process for coverage decisions related to experimental or investigational therapies. If Cigna denies your appeal because the requested service or treatment is experimental or investigational, Cigna will send you a letter within 5 business days of making the denial decision. The letter will include:

- A notice explaining your right to an IMR;
- An IMR application;
- A Physician Certification Form for your physician to complete which certifies that you have a life-threatening or seriously debilitating condition; Your physician's certification must also indicate that standard therapies have not been effective in treating your condition or the requested therapy is likely to be more beneficial than any standard therapy as documented in two separate sources of medical or scientific evidence.
- An envelope for you to return the completed forms to Us.

A "life-threatening" condition means either or both of the following:

(i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival

A "seriously debilitating" condition means diseases or conditions that cause major irreversible morbidity.

"Medical and scientific evidence" means any of the following:

1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

2) Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS data base Health Services Technology Assessment Research (HSTAR).

3) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.

4) Either of the following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Dental Association Accepted Dental Therapeutics and The United States Pharmacopoeia-Drug Information.

5) Any of the following reference compendia if recognized by the Federal Center for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (A) The Elsevier Gold Standard's Clinical Pharmacology, (B) The National Comprehensive Cancer Network Drug and Biologics Compendium (C) The Thomson Micromedex DrugDex

6) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

7) Peer-reviewed abstracts accepted for presentation at major medical association meetings.

The IMR will be conducted by an Independent Medical Review Organization which is qualified to review issues related to experimental and investigational therapies as selected by the CDI. The IMR must be completed within 30 calendar days. If Your physician determines that the proposed therapy which is the subject of the IMR would be significantly less effective if not initiated promptly, an expedited IMR is available. An expedited IMR will be completed within 7 calendar days from the date an expedited IMR was requested. This timeframe may be extended by up to 3 calendar days if there is a delay in providing any documents which the Independent Medical Review Organization requests for review. The IMR's decision must state the reason that the therapy should or should not be covered, citing your specific medical condition, the relevant documents, and the relevant medical and scientific evidence. Cigna will cover the services subject to the terms and conditions generally applicable to other benefits under Your plan.

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: IMR300 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.

For those cases or disputes for medical malpractice which the total amount of damages claimed is fifty thousand dollars ($50,000) or less, the parties will select a single neutral arbitrator who shall have no jurisdiction to award more than fifty thousand dollars ($50,000). If the parties are unable to agree on the selection of a single neutral arbitrator, the method provided in Section 1281.6 of the Code of Civil Procedure shall be utilized. The selection of the single arbitrator for malpractice claims only is not subject to waiver by the policy.

For claims other than malpractice the parties will follow California Code of Civil Procedure Section 1281.96. When an arbitrator appointed fails to act and his or her successor has not been appointed, the court, on petition of a party to the arbitration agreement, shall appoint the arbitrator.

When a petition is made to the court to appoint a neutral arbitrator, the court shall nominate five persons from lists of persons supplied jointly by the parties to the arbitration or obtained from a governmental agency concerned with arbitration or private disinterested association concerned with arbitration. The parties to the agreement who seek arbitration and against whom arbitration is sought may within five days of receipt of notice of the nominees from the court jointly select the arbitrator whether or not the arbitrator is among the nominees.

If the parties fail to select an arbitrator within the five-day period, the court shall appoint the arbitrator from the nominees. Arbitration procedures will be in compliance with California Code of Civil Procedure Section 1281.96. Parties must mutually agree to a time and place for 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.)

Terms of the Policy

Entire Contract, Changes: This Policy, including the 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.

Statements Not Warranties
All statements and descriptions in any application for insurance or in negotiations therefore, by or in behalf of the Insured Person, shall in the absence of fraud, be deemed to be representations and not warranties. Any express warranties made at or before the execution of the policy shall be contained in the policy, or in another instrument signed by the Insured Person or referred to in the Policy as making a part of it.

Grace Period 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.

Class Action Waiver: Except as provided by California law under this provision of this Policy, You (including any legal representative acting on Your behalf) 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 California law, under this provision of the Policy 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.

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 31st day of the grace period for plans not purchased from the 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 in the first 24 months after the Policy is issued.

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.
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 Dependent (s) no longer live in the State of California.
8. When Cigna determines that any premium payment for this Policy is being paid directly or indirectly from any source other than You, Your Family Members or an Acceptable Third Party Payor; however, if You, Your Family Members or an Acceptable Third Party Payor make all premium payments for this Policy that are due after the date of Cigna's determination, the Policy shall remain in effect, subject to all other terms and conditions contained herein.

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 5 days prior to cancellation.

Additional Programs: We may, from time to time offer, or arrange for various entities to offer, discounts, benefits, or other consideration to You for the purpose of promoting Your general health and well-being.

Modification of Coverage:
We have the right upon renewal to modify or otherwise change the terms and conditions of Your Policy, including premiums, once per Year upon renewal, provided that We give You 60 days written notice of such modifications or changes. Such modifications or changes may alter any term or benefit of this Policy, including without limitation, premiums, Covered Services, Deductibles, Copayments or Coinsurance. Any modifications made to this Policy will comply with federal uniform modification of coverage requirements.

In addition to the 60 days written notice provision set forth above Our right to modify the Policy under the paragraph above is subject to the following conditions:

1. We will not cancel or modify this Policy under this paragraph on an individual basis but only for all Insureds in the same class and covered under the same Policy as You except:
   (a) if We discover any fraud or intentional misrepresentation of material fact under the terms of the coverage by an individual,
   (b) if We find out about any fraud or deception in the use of the benefits of this Policy by You, Your enrolled Dependent or anyone else if You or any Insured Person in Your family knows about it.

The modifications or changes will take effect annually upon the next renewal date of the Policy. .

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. However, 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.

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.

Renewal: This Policy renews on a Calendar Year basis.

Exception for Insured Persons deployed by or called to Active Duty in the United States military: Upon application for reinstatement, We will provide the Policyholder deployed by or called to active duty in the military the same benefits in effect before the policy lapsed.

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 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.

Limiting Age:
If We accept premium payment for Your Dependent beyond the limiting age, We will provide coverage until the end of the period for which premium has been accepted.

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 33650-3365

- 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 Dependent(s) may be materially and adversely affected.

- 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.

Continuity of Care for Current Members

Upon Your request, Cigna shall provide or arrange for the completion of covered services from a terminated Participating Provider if you have one of the following conditions and were receiving services from the terminated Participating Provider at the time of the contract termination. You will qualify to receive continued services for the following conditions and specified time periods:

- **An acute condition**. An acute condition is a medical condition that involves a sudden onset of symptoms due to an Illness, Injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- **A serious chronic condition**. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, in consultation with you and the terminated Provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date.
- **A pregnancy.** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
- **A terminal illness.** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness.
- **Newborn Child.** The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date.
- **Surgery.** Performance of a surgery or other procedure that is authorized by Cigna as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

Provider's Responsibility. In order for a terminated Participating Provider to continue caring for a Cigna Insured, the terminated Participating Provider must comply with Cigna's contractual and credentialing requirements and must meet Cigna's standards for utilization review and quality assurance. The terminated Participating Provider must also agree to a mutually acceptable rate of payment. If these conditions are not met, Cigna is not required to arrange for continuity of care.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

Policy Benefits

Participating Providers
Copayment, deductible, and coinsurance options reflect the amount the covered person will pay for in-network and out-of-network benefits. In-network benefits require use of Participating Providers or facilities in the Service Area. Cigna recommends use of Participating Providers and facilities, as member out-of-pocket costs could be lower than when using non-Participating Providers.

Cigna will notify You of any termination or permanent breach of contract by, or permanent inability to perform of, any Participating Provider if such termination, breach or inability would materially and adversely affect You.

Service Area
The term Service Area means the area in which Cigna has a Participating Provider network. Cigna's national network of Participating Providers is within the United States. Cigna's toll-free care line personnel can provide you with the names of Participating Providers. If You or Your Dependents need medical care, You may obtain a listing of Participating Providers by calling the number on Your I.D. card. A listing of Participating Providers can also be found at www.Cigna.com.

Away From Home Care
If You or Your Dependents need medical care while away from home, You may have access to a national network of Participating Providers through Cigna's Away-From-Home Care feature. Call the number on Your I.D. card for the names of Participating Providers in other network areas.

Emergency Services
Benefits for services and supplies received outside the Service Area from Foreign Country Providers are covered only 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.

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 Dependent(s).

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.

How to File a Claim for Benefits

Notice of Claim: Written notice of claim must be given within 60 days after the occurrence or commencement of any loss covered by the Policy. The notice can be given to Us at the address shown on the first page of this Policy or the address on ID card. Notice should include the name of the Insured, and claimant if other than the Insured, and the Policy identification number.

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: 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.

Proof of Loss: You must give Us written proof of loss within 15 months after the date of the loss. Proof of loss is a claim form or letter 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. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

Assignment of Claim Payments:

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 to a provider licensed and practicing within the United States.

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

Payment for services provided by a Participating Provider is automatically assigned to the provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating Provider is responsible for filing the claim and We will make payments to the provider for any benefits payable under this Policy. Payment for services provided by a Non-Participating Provider are payable to the Insured Person unless assignment is made as above except that payment will be made directly to licensed ambulance providers, certified nurse-midwives, nurse practitioners and licensed midwives. If payment is made to the Insured Person for 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.

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 Policy neither regulate the amounts charged by providers of medical care nor attempt to evaluate those services. However, the amount of benefits payable under this Policy will be different for Non-Participating Providers than for Participating Providers.

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of that loss, be paid directly to the person or persons having paid for the hospitalization or medical or surgical aid, or to the hospital or person rendering those services; but it is not required that the service be rendered by a particular hospital or person.

Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

Claim Determination Procedures Under Federal Law (Provisions of the laws of California 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 pre-service, concurrent, or post-service basis, as described below.

Certain services require prior authorization in order to be covered. This prior authorization is called a "pre-service 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.

Pre-service 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 5 business 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 5 business 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 pre-service medical necessity determination, Cigna will notify them of the failure and describe the proper procedures for filing within 5 days (or 72 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

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.

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 premium payment grace period of 31 calendar days. If payment hasn't been received, Cigna will send a written notice of intent to terminate coverage for non-payment of premium no later than the last day of coverage for which Cigna received payment. The grace period begins on the date this notice was mailed. Coverage will continue during the 31 day grace period, however, coverage will be terminated retrospectively to the date your premium was paid through, if premium isn't paid during the grace period.

Your premium may change 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 Health and Life Insurance Company may change the premiums of this Policy only once per Calendar Year, on January 1st at renewal, after 60 days' written notice to the Insured Person. 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. If CIGNA receives any payment of premium in respect of this Agreement directly or indirectly from any source other than You, Your Family Members or an Acceptable Third Party Payor, such payment will be considered a basis for the cancellation of this Agreement.