Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 days written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
Tennessee Cigna Health Savings 6000 Plan
and
Native American / Alaskan Native Over 300% Plan

If You Wish To Cancel Or If You Have Questions

If You are not satisfied, for any reason, with the terms of this Policy You may return it to Us within 10 days of receipt. We will then cancel Your coverage as of the original Effective Date and promptly refund any premium You have paid. This Policy will then be null and void. If You wish to correspond with Us for this or any other reason, write:

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

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

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

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

Guaranteed Renewable

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

Signed for Cigna by:

Matthew G. Manders, President

Anna Krishtul, Corporate Secretary

IMPORTANT NOTICE

Direct Access to Obstetricians and Gynecologists

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

Selection of a Primary Care Provider

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

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

Table of Contents

INTRODUCTION 1

About This Policy 1
Note Regarding Health Savings Accounts 1
Important Information Regarding Benefits 2
Prior Authorization Program 2
BENEFIT SCHEDULE 4

DEFINITIONS 15

WHO IS ELIGIBLE FOR COVERAGE? 25

Eligibility Requirements 25
When Can I Apply? 26
Specific Causes for Ineligibility 27
Continuation 28

HOW THE POLICY WORKS 29

Benefit Schedule 29
Special Circumstances 29
Deductibles 30
Out-of-Pocket Maximums 30
Special Limits 31
Penalties 31

COMPREHENSIVE BENEFITS: WHAT THE POLICY PAYS FOR 32

Services and Supplies Provided by a Hospital or Free-Standing Outpatient Surgical Facility 32
Services and Supplies Provided by a Skilled Nursing Facility 32
Hospice Services 33
Ambulance Services 34
Services for Cardiac Rehabilitation 34
Habilitative Services 35
Dental Procedures Performed on Minors in Hospitals 35
Pregnancy and Maternity Care 36
Preventive Care Services (birth and older) 36
Genetic Testing 37
Hearing Aids 37
Autism Spectrum Disorders 37
Organ and Tissue Transplants 38
Clinical Trials 40
Treatment of Diabetes 41
Treatment Received from Foreign Country Providers 41
Telehealth/Telemedicine Medical Services 41
Home Health Care 41
Smoking Cessation 42
Injury While Intoxicated or Under the Influence of a Narcotic 42
Mastectomy and Related Procedures 42
Phenylketonuria Treatment 42

EXCLUSIONS AND LIMITATIONS: WHAT IS NOT COVERED BY THIS POLICY 44

Excluded Services 44

PRESCRIPTION DRUG BENEFITS **48**

PHARMACY PAYMENTS 48
COVERED EXPENSES 48
WHAT IS COVERED 48
CONDITIONS OF SERVICE 49
EXCLUSIONS 49
LIMITATIONS 50
PHARMACY FORMULARY EXCEPTION 51
PROCESS/PRIOR AUTHORIZATION – COVERAGE OF NEW DRUGS 51
PHARMACY FORMULARY EXCEPTION PROCESS/PRIOR AUTHORIZATION 51
REIMBURSEMENT/FILING A CLAIM 51
CLAIMS AND CUSTOMER SERVICE 52

PEDIATRIC VISION SERVICES PERFORMED BY AN OPHTHALMOLOGIST OR OPTOMETRIST **53**

DEFINITIONS 53
PEDIATRIC VISION BENEFITS 53
WHAT'S COVERED 53
EXCLUSIONS 54
LIMITATIONS 54
CIGNA VISION PROVIDERS 55
REIMBURSEMENT/FILING A CLAIM 55

GENERAL PROVISIONS **56**

EXPENSES FOR WHICH A THIRD PARTY MAY BE LIABLE 56
ALTERNATE COST CONTAINMENT PROVISION 56
OTHER INSURANCE 56
WHEN YOU HAVE A COMPLAINT OR AN APPEAL 57
TERMS OF THE POLICY 60
OTHER INSURANCE WITH THIS INSURER 63
OPPORTUNITY TO SELECT A PRIMARY CARE PHYSICIAN 63
HOW TO FILE A CLAIM FOR BENEFITS 63

PREMIUMS **67**

Introduction

About This Policy

Your medical coverage is provided under a Policy issued by Cigna Health and Life Insurance Company ("Cigna"). This Policy is a legal contract between You and Us.

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

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

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

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

If, within 2 years after the Effective Date of Your participation in the Policy, We discover any fraud or material facts that were INTENTIONALLY misrepresented or that You or Your Family Member (s) knew, but intentionally did not disclose in Your application, We may rescind this Coverage as of the original Effective Date. Additionally, if within 2 years after adding additional Family Member(s) (excluding newborn children of the insured added within 61 days after birth), We discover any material facts that were INTENTIONALLY misrepresented or that You or Your Family Member (s) knew, but did not disclose in Your application, We may rescind coverage for the additional Family Member(s) as of the date he or she originally became effective. If We rescind Your coverage, We will provide you with 30 days advance notice and We will refund all premiums You paid for your Policy less the amount of any claims paid by Cigna. Rescission of Your coverage will result in denial of all pending claims and, if claim payments exceed total premiums paid, then claims previously paid by Cigna will be retroactively denied, obligating You to pay the provider in full for services rendered at the provider's regular billed rate, not at the Cigna Negotiated Rate.

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

Note Regarding Health Savings Accounts

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.**

Important Information Regarding Benefits

Prior Authorization Program

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

Prior Authorization For Inpatient Services

Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION to a Hospital or certain other facilities MAY RESULT IN A PENALTY.

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

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

- call Cigna at the number on the back of your ID card, or
- check www.mycigna.com, under “View Medical Benefit Details"

Please note that emergency admissions will be reviewed post admission.

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

Prior Authorization Of Outpatient Services

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

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

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

- call Cigna at the number on the back of your ID card, or
- www.check mycigna.com, under “View Medical Benefit Details"

PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. Prior Authorization does not guarantee payment of benefits. Coverage is always subject to other requirements of this Policy, such as limitations and exclusions, payment of premium and eligibility at the time care and services are provided.

Retrospective Review

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

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

BENEFIT SCHEDULE

The following is the Plan Benefit Schedule including medical, prescription drug and pediatric vision benefits. The Policy sets forth, in more detail, the rights and obligations of both You and your Family Member(s) and the Plan. It is, therefore, important that all Insured Person's **READ THE ENTIRE POLICY CAREFULLY!**

NOTE:
The benefits outlined in the table below show the payment for Covered Expenses. Coinsurance amounts shown below are Your responsibility after any applicable deductible or copayment have been met, unless otherwise indicated. Copayment amounts shown are also Your responsibility.

BENEFIT INFORMATION **Note: Covered Services are subject to Annual Plan Deductible unless specifically waived.**	**IN-NETWORK – YOU PAY (Based on Cigna contract allowance)**	**OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)**
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Medical Benefits		
Annual Plan Deductible Individual Family	**In-Network Deductible** $6,000 $12,000	**Out-of-Network Deductible** $12,500 $25,000
Out-of-Pocket Maximum Individual Family	**In-Network Out-of-Pocket Maximum** $6,500 $13,000 The following do not accumulate to the In-Network Out-of-Pocket Maximum: Penalties and Policy Maximums.	**Out-of-Network Out-of-Pocket Maximum** $25,000 $50,000 The following do not accumulate to the Out-of-Network Out-of-Pocket Maximum: Penalties and Policy Maximums.
Coinsurance	You and Your Family Members pay 0% of Charges after the Annual Plan Deductible	You and Your Family Members pay 50% after the Annual Plan Deductible

BENEFIT INFORMATION Note: Covered Services are subject to Annual Plan Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Prior Authorization Program		
Prior Authorization – Inpatient Services	**Your Provider must obtain approval** for inpatient admissions; or **Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for inpatient admission; or **You may be assessed a $500 penalty** for non-compliance.
Prior Authorization – Outpatient Services NOTE: Please refer to the section on Prior Authorization of inpatient and outpatient services for more information. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of your ID card or at www.mycigna.com under "View Medical Benefit Details".	**Your Provider must obtain approval** for outpatient procedures and diagnostic testing; or **Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for certain outpatient procedures and services; or **You may be assessed a $60 penalty** for non-compliance.
All Preventive Well Care Services Please refer to "Comprehensive Benefits: What the Policy Pays For" section of this Policy for additional details.	0%, Deductible waived	50%
Pediatric Vision Care Care Performed by an Ophthalmologist or Optometrist for Insured Persons less than 19 years of age. **Please be aware that the Pediatric Vision network is different from the network of your medical benefits**		
Comprehensive Eye Exam and Refraction for Children Limited to one exam per year	0%, Deductible waived	You pay all but $30 per exam
Eyeglasses and Lenses for Children	0%, Deductible waived	
Frames		You pay all but $30 per frame
Single Vision		You pay all but $25 per pair
Lined Bifocal		You pay all but $35 per pair
Lined Trifocal or Lenticular		You pay all but $45 per pair
Limited to one pair per year		

BENEFIT INFORMATION Note: Covered Services are subject to Annual Plan Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Contact Lenses for Children Elective Therapeutic Limited to one pair per year **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	0%, Deductible waived	You pay all but $75 per pair You pay all but $225 per pair
Physician Services		
Office Visit		
Primary Care Physician (PCP)	0%	50%
Specialist, (including consultant, referral and second opinion services)	0%	50%
Surgery in Physician's office	0%	50%
Outpatient Professional Fees for Surgery (including surgery, anesthesia, diagnostic procedures, radiation therapy)	0%	50%
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	0%	50%
In-hospital visits	0%	50%
Allergy testing and treatment/injections	0%	50%

BENEFIT INFORMATION Note: Covered Services are subject to Annual Plan Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Hearing Aids for children **Maximum one hearing aid per ear every 3 years** **Note:** Services necessary to select, fit and adjust the hearing aid are included in the benefit.	0%	50%
Hospital Services		
Inpatient Hospital Services		
Facility Charges	0%	50%
Professional Charges	0%	50%
Emergency Admissions		
Facility Charges	0%	50%
Professional Charges	0%	50%
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital Facilities	0%	50%
Emergency Services		
Emergency Room	0%	In-network benefit level for an emergency medical condition, otherwise 50%
Ambulance Emergency transportation to the nearest facility capable of handling the emergency only.	0% for Ground or Air transport	In-network benefit level for an emergency medical condition, otherwise 50% for Ground or Air transport
Urgent Care	0%	In-network benefit level for an emergency medical condition, otherwise 50%

BENEFIT INFORMATION Note: Covered Services are subject to Annual Plan Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation charges	0%	50%
All Other Laboratory and Radiology Services Facility and interpretation charges		
Physician's Office	0%	50%
Free-standing/Independent lab or x-ray facility	0%	50%
Outpatient hospital lab or x-ray	0%	50%
Short-Term Rehabilitative Services Physical, Occupational, Speech, and Chiropractic Therapy Maximum of 20 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders.	0%	50%
Cardiac & Pulmonary Rehabilitation Maximum of 36 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined	0%	50%
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	0%	50%

BENEFIT INFORMATION Note: Covered Services are subject to Annual Plan Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Habilitative Services Including Physical, Occupational, and Speech Therapy Maximum of 20 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined. **Note**: Maximums for Short-term Rehabilitative services do not apply to Habilitative services. Maximums for Habilitative Services do not apply to services for the treatment of Autism Spectrum Disorders.	0%	50%
Women's Contraceptive Services, Family Planning and Sterilization	0%, Deductible waived	50%
Male Sterilization	Copay or Coinsurance applies for specific benefit provided	50%
Maternity (Pregnancy and Delivery) /Complications of Pregnancy Initial Office Visit to confirm pregnancy and subsequent prenatal visits billed separately from the "global" fee		
Primary Care Physician (PCP)	0%	50%
Specialist Physician	0%	50%
Prenatal services, Postnatal and Delivery (billed as "global" fee)	0%	50%
Hospital Delivery charges	0%	50%
Prenatal testing or treatment billed separately from "global" fee	0%	50%
Postnatal visit or treatment billed separately from "global" fee		
Primary Care Physician (PCP)	0%	50%
Specialist Physician	0%	50%

BENEFIT INFORMATION Note: Covered Services are subject to Annual Plan Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Dental Care (other than Pediatric) Limited to treatment for accidental injury to natural teeth within six months of the accidental injury Also includes anesthesia for dental procedures for a child.	0%	50%
Treatment of Diabetes (Pharmaceuticals for monitoring or treatment of diabetes are covered under the prescription drug benefit)	0%	50%
Medical Services for Treatment of Phenylketonuria (PKU)	0%	50%
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 60 days per Insured Person per calendar year, combined In- and Out-of-Network, for all facilities listed	0%	50%
Home Health Services Maximum 60 visits per Insured Person, per calendar year. Maximum 16 hours per day Maximum 8 visits per day	0%	50%
Durable Medical Equipment	0%	Not Covered
Prosthetics	0%	50%
Hospice		
Inpatient	0%	50%
Outpatient	0%	50%

BENEFIT INFORMATION Note: Covered Services are subject to Annual Plan Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Dialysis		
Inpatient	Inpatient Hospital Services benefit applies	Not Covered
Outpatient	0%	Not Covered
Autism Spectrum Disorders		
Diagnosis of Autism Spectrum Disorder		
Office Visit	0%	50%
Diagnostic Testing	0%	50%
Treatment of Autism Spectrum Disorder (see "Comprehensive Benefits: What the Policy Pays For" section for specific information about what services are covered)	Copay or Coinsurance applies for specific benefit provided	50%
Mental, Emotional or Functional Nervous Disorders		
Inpatient (Includes Acute and Residential Treatment)	0%	50%
Outpatient (Includes individual, group, intensive outpatient and partial hospitalization)		
Office Visit	0%	50%
All other outpatient services	0%	50%
Substance Use Disorder		
Inpatient Detoxification/Rehabilitation (Includes Acute and Residential Treatment)	0%	50%
Outpatient (Includes individual, group, intensive outpatient and partial hospitalization)		
Office Visit	0%	50%
All other outpatient services	0%	50%

BENEFIT INFORMATION Note: Covered Services are subject to Annual Plan Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Organ and Tissue Transplants (see benefit detail in "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.)		
Cigna LIFESOURCE Transplant Network® Facility	0%	NOT APPLICABLE
Travel Benefit, (Only available through Cigna Lifesource Transplant Network ® Facility) Travel benefit Lifetime maximum payment of $10,000		
Other Cigna Network Facility	0%	NOT APPLICABLE
Out-of-Network Facility	NOT APPLICABLE	NOT APPLICABLE
Infusion and Injectable Specialty Prescription Medications and related services or supplies	0%	50%

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
In the event that You request a "brand-name" drug that has a generic equivalent, You will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the "generic" Copay or Coinsurance shown in the Benefit Schedule.		
Prescription Drug Deductible	Integrated Medical and Prescription Drug Deductible	
Cigna Retail Pharmacy Drug Program	**YOU PAY PER PRESCRIPTION OR REFILL:**	**YOU PAY PER PRESCRIPTION OR REFILL:**
Tier 1: Retail Preferred Generic Up to a 90-day maximum supply.	0% per Prescription or refill	Not Covered
Tier 2: Retail Non-Preferred Generic Up to a 90-day maximum supply.	0% per Prescription or refill	Not Covered
Tier 3: Retail Preferred Brand Up to a 90-day maximum supply.	0% per Prescription or refill	Not Covered
Tier 4: Retail Non-Preferred Brand Up to a 90-day maximum supply.	50% per Prescription or refill	Not Covered
Tier 5: Specialty generic and brand name medications that meet criteria of specialty drugs Up to a 30-day maximum supply.	0% per Prescription or refill	Not Covered
Retail Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including women's contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative Up to a 90-day maximum supply.	0%, Deductible waived per Prescription or refill	Not Covered

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Cigna Mail Order Pharmacy Drug Program		
Tier 1: Mail Order Preferred Generic 90-day maximum supply.	0% per Prescription or refill	Not available
Tier 2: Mail Order Non-Preferred Generic 90-day maximum supply.	0% per Prescription or refill	Not available
Tier 3: Mail Order Preferred Brand 90-day maximum supply.	0% per Prescription or refill	Not available
Tier 4: Mail Order Non-Preferred Brand 90-day maximum supply.	50% per Prescription or refill	Not available
Tier 5: Specialty generic and brand name medications that meet criteria of specialty drugs 30-day maximum supply.	0% per Prescription or refill	Not available
Mail Order Pharmacy Preventive Drugs regardless of Tier Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including women's contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative 90-day maximum supply.	0%, Deductible waived per Prescription or refill	Not available

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.

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

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

Autism Spectrum Disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

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 Company), or an affiliate. Cigna is a licensed and regulated insurance company operating throughout the United States.

Coinsurance means the percentage of Covered Expenses the Insured Person is responsible for paying after applicable Deductibles are satisfied). **Coinsurance does not include Copayments. Coinsurance also does not include charges for services that are not Covered Services or charges in excess of Covered Expenses, or charges which are not Covered Expenses under this Policy.**

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

Cosmetic Surgery is performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance. **Cosmetic Surgery Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.**

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

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

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

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

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

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

Diabetes Equipment includes, but is not limited to, blood glucose monitors, including monitors designed to be used by blind persons; insulin pumps and associated appurtenances; to include insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices in the injection of insulin and any other required disposable supplies. Podiatric appliances 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 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, blood glucose monitors on Cigna's Prescription Drug List, ketones and protein; lancets and lancet devices; insulin and insulin analogs, injection aids; including devices used to assist with insulin injection and needle less systems; syringes and needles, biohazard disposal containers, prescriptive and non-prescriptive agents for controlling blood sugar levels, and glucagon emergency kits.

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

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

1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2) serious impairment to bodily functions; 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;
- 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 cover other Family Member(s). Each Insured Person can contribute up to the Individual In-Network Deductible amount toward the Family In-Network Deductible. The Individual In-Network Deductible paid by each Family Member counts towards satisfying the Family In-Network Deductible. Once the Family In-Network Deductible amount is satisfied, the remaining Individual In-Network Deductibles will be waived for the remainder of the Year. The amount of the Family In-Network Deductible is described in the Schedule of Benefits section of this Policy.

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

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

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

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

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

Free-Standing Outpatient Surgical Facility
The term Free-Standing Outpatient Surgical Facility means an institution which meets all of the following requirements:
- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

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

Habilitative Services are those services that are

(i) designed to assist a child to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame,

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

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

Hearing Aid is any wearable, nonexperimental, nondisposable instrument or device designed for the ear and used to aid or compensate for impaired human hearing, including earmolds and services necessary to select, fit, and adjust the hearing aid, but excluding batteries, cords, and other assistive listening devices such as FM systems.

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.

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

Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Agency and Visiting Nurse Associations (d) a hospice facility, or (e) any other licensed facility or agency under a hospice care program.

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

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

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

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

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

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

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

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

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

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

Injury means an accidental bodily injury.

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

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

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

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

- The provider's normal charge for a similar service or supply; or
- 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.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Within generally accepted standards of good medical practice within the community 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 satisfy 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.

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 subacute facilities.

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

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

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

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

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

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

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

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

Physician is a Physician licensed to practice medicine or any other practitioner who is licensed and recognized as a provider of health care services 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, 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 January 1st of each 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 List is a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

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

Primary Care Physician is a Physician:

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

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

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

Prostheses/Prosthetic Appliances and Devices 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.

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

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 and 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), and
- disposable needles and syringes needed for injecting covered drugs and supplements.

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

Service Area is any place that is within the counties, cities and/or zip code areas in the state of Tennessee that Cigna has designated as the Service Area for this Plan. For specific information regarding Your Service Area, please check www.mycigna.com or call 800-244-6224.

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

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

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

Smoking Cessation Attempt means 4 tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling); and certain Food and Drug Administration (FDA)-approved tobacco cessation medications (including prescription medications and over-the-counter medications with a Physician's prescription) for a 90-day treatment regimen. Please see your Prescription Drug List for details.

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

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.

Telemedicine Medical Service is a health care service initiated or provided by a Physician for purposes of patient assessment, diagnosis, consultation, treatment or the transfer of medical data, that requires the use of advanced telecommunications technology other than by telephone or facsimile.

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.

Urgent Care means medical, surgical, Hospital and related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the Service Area where You ordinarily receive and/or are scheduled to receive services.

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

Who Is Eligible For Coverage?

Eligibility Requirements

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

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

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

Other Insured Persons may include the following Family Member(s):

- Your lawful spouse.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, or Your spouse's children, regardless of age, enrolled prior to age 26, who are incapable of self-sustaining employment by reason of intellectual or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's Newborn children are automatically covered for the first 31 days of life. To continue coverage past that time You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date of birth, and pay any additional premium. Coverage for a newborn dependent child enrolled within 61 days of birth will be retroactive to the date of the child's birth.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage past that time, You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date of adoption and pay any additional premium. Coverage for an adopted dependent child enrolled within 61 days of adoption will be retroactive to the date of the child's placement for adoption or initiation of a suit of adoption.
- If a court has ordered an Insured to provide coverage for an eligible child (as defined above) coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage past that time, You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the court order date, and paying any additional premium. Court-ordered coverage for a dependent child enrolled within 61 days of the court order will be retroactive to the date of the court order.
- A minor child who is by court or administrative order in the custody of a guardian who is a resident of Tennessee and covered under this policy.

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 for coverage or change coverage from one plan to another.

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

Your coverage under this Policy will then become effective upon the earliest day allowable under federal rules for that Year's Annual Open Enrollment Period**. Note: If You do not apply to obtain or change coverage during the Year's 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 qualified 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, and any dependent(s), loses his or her minimum essential coverage; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gaining or becoming a dependent by marriage, birth, adoption or placement for adoption; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee or death of the covered employee; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status (This is only applicable to the marketplace); or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the Federally Facilitated Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the marketplace. In such cases, the marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or

- An eligible individual adequately demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month (This is only applicable to coverage on the Marketplace);
- An eligible individual or enrollee demonstrates to the marketplace, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the marketplace may provide.

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

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

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

For all other triggering events the effective dates are:

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

Specific Causes for Ineligibility

Except as described in the Continuation section, an Insured Person **will become ineligible for coverage** under the Policy:

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

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

Continuation

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

How The Policy Works

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

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

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

Benefit Schedule

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

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

Participating Hospitals, Participating Physicians and Other Participating Providers.

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

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

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

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

Under this circumstance benefits will be provided as follows:

- **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 Family Member(s), the Family In-Network Deductible will apply. Each Insured Person can contribute up to the individual In-Network Deductible amount toward the Family In-Network Deductible. Once this Family In-Network Deductible is satisfied, no further Family In-Network Deductible is required for the remainder of that Year.

Out-of-Network Deductible

The Out-of-Network Deductible is applied only to Covered Expenses incurred for services received from Non-Participating Providers. If the Insured Person submits a claim for services which has a maximum payment limit and the Out-of-Network Deductible is not satisfied, We will only apply the allowed per visit, per day, or per event amount, whichever applies, toward the Out-of-Network Deductible. Only Maximum Reimbursable Charges will be applied to the Out-of-Network Deductible. Please see Policy Details for how Maximum Reimbursable Charges are calculated.

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

Out-of-Pocket Maximums

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

- Once an Insured Person(s) reaches the Out-of-Pocket Maximum for either Participating or Non-Participating Providers in a Calendar Year, the Insured Person will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.

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

Special Limits

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

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

Penalties

A Penalty is an amount of Covered Expenses that is:

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

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

Penalties will apply under the following circumstances:

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

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

Comprehensive Benefits: What the Policy Pays For

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

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

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

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

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

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

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

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

Payments of Inpatient Covered Expenses are subject to these conditions:

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

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

Services and Supplies Provided by a Skilled Nursing Facility

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

For any eligible condition that is Authorized by Cigna, this Policy provides indicated benefits for Covered Expenses for:

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

Note: No benefits will be provided for:

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

Hospice Services

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

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

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

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

Professional and Other Services

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

This Policy provides benefits for Covered Expenses incurred for:

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

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

Cigna determines whether the item meets these conditions.

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

Ambulance Services

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

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

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

Ambulance transportation is covered for emergency situations only, to the nearest facility capable of handling the emergency.

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

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

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

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

Benefits for Covered Expenses will be provided for speech therapy, including services of a licensed audiologist, speech therapist or Physician for speech therapy. These services are payable up to the number of visits as stated in the Benefit Schedule.

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

Special Note:

- Additional visits for Physical or Occupational Therapy may be covered following severe trauma such as:
- an inpatient hospitalization due to severe trauma, such as spinal Injury or stroke; and
- Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment; and
- Cigna authorizes this in advance.

Services for Cardiac Rehabilitation

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

This Policy provides benefits for Covered Expenses incurred for:

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

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

Habilitative Services

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

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

Benefits for services designed to assist a child to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame are payable up to the maximum number of visits as stated in the Benefit Schedule.

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

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

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

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

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

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

- Services must be for the treatment of a Mental, Emotional or Functional Nervous Disorder, or Substance Use Disorder and medical complications of mental illness or mental retardation that can be improved by standard medical practice.
- The Insured Person must be under the direct care and treatment of a Physician for the condition being treated.
- Services must be those which are regularly provided and billed by a Hospital or a Physician.
- Services are covered only for the number of days or visits which are Medically Necessary to treat the Insured's condition.
- Inpatient services must be received in a Hospital or Day Care Center for inpatient treatment.

Dental Care

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

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

1. services must be received during the 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.

Dental Procedures Performed on Minors in Hospitals

Benefits are payable for charges for anesthesia, Hospital and Physician expenses for inpatient or outpatient Hospital dental procedures performed on a child when the procedure cannot safely be performed in a dental office.

Pregnancy and Maternity Care

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

Your Participating Provider Plan provides pregnancy and postdelivery care benefits for You and Your Family Members

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

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

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

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

Preventive Care Services (birth and older)

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

The Plan provides benefits for routine preventive care services. Payment will be provided for Covered Expenses for preventive care services including but not limited to the following:

- Routine physical exams.
- Annual mammogram, Pap test and PSA.
- Items or services that have an A or B rating in current recommendations of the U. S. Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- For women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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

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

Genetic Testing

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

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

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

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

Hearing Aids

Hearing aids for children are covered as specified in the Benefit Schedule.

Autism Spectrum Disorders

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

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

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

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

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

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

Organ and Tissue Transplants

To be eligible for benefits, organ and tissue transplants must be Prior Authorized by Cigna before services are rendered (see the "Prior Authorization Program").
(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

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

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

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

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

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

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

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

The Cigna LIFESOURCE Transplant Network® Facility benefit includes the following **travel expense benefits** that will be provided for:

- The recipient and 1 travel companion, when the recipient is an Insured Person.
- The donor, if the recipient is an Insured Person.

The travel expense benefit is provided in connection with a covered organ or tissue transplant **only** if Covered Services are provided by a designated Cigna LIFESOURCE Transplant Network® Facility. Transportation expenses, meals, and lodging expenses for the recipient and 1 companion and a donor will be paid **only** if there is not a qualified Cigna LIFESOURCE Transplant Network® Facility within 100 miles of the recipient's home. The recipient must utilize services at the closest qualified Cigna LIFESOURCE Transplant Network® Facility. All travel expenses must be Prior Authorized by Cigna.

Travel expenses for organ and tissue transplants are limited to a combined maximum reimbursement as shown in the Plan Benefit Schedule.

Cigna LIFESOURCE Transplant Network® Facility Benefit Exclusions and Limitations

Benefits that are payable under this provision are subject to the following limitations:

- Transportation as a passenger in or on a public vehicle provided by a common carrier for passenger service to the Cigna LIFESOURCE Transplant Network® Facility is limited to the amount equal to the cost of a round-trip coach airfare to the Facility.
- Transportation to the Cigna LIFESOURCE Transplant Network® Facility using a motor vehicle, will be payable in accordance with the current IRS allowance per mile for medical travel and is limited to the cost of a round-trip coach airfare to the Facility.
- Hotel accommodations, daily meals and other reasonable and necessary services or supplies incurred by an Insured Person and a travel companion will be limited to $200 per day.

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

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

The following Organ and Tissue Transplant Travel Benefit charges are <u>excluded from payment under the Plan</u>:

- Transportation expenses, lodging and meals when the Cigna LIFESOURCE Transplant Network® Facility is less than100 miles from the Insured Person's home.
- Charges incurred by more than one travel companion.
- Charges incurred by the Insured Person and a travel companion for transportation, lodging and meals other than what is reasonable and necessary for the treatment Plan.
- Charges in connection with the travel allowance benefit that is not incurred for the treatment Plan at a Cigna LIFESOURCE Transplant Network® Facility, except travel days.
- Charges incurred for transportation for a travel companion other than the trip required to accompany the Insured Person to and from the Facility.
- Charges for the repair or maintenance of a motor vehicle.
- Personal expenses incurred to maintain the Insured Person and a travel companion's residence while the Insured Person and a travel companion are traveling to and from the Facility and during the Insured Person's length of stay. Some examples of these personal expenses include, but may not be limited to: child care costs, house sitting costs, or pet kennel charges.
- Charges for personal comfort or convenience items.
- Charges for alcohol, drugs or tobacco.
- Reimbursement of any wages lost by the Insured Person and a travel companion for the treatment Plan.
- Travel expenses incurred while receiving treatment at a facility that is not designated as a Cigna LIFESOURCE Transplant Network® Facility.

Clinical Trials

Benefits are payable for routine patient care costs related to an approved clinical trial (Phases I-IV), for cancer or life-threatening diseases or conditions for an Insured who meets the following requirements:

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

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

The clinical trial must meet one of the following requirements:

1. Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
2. Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
3. Involve a drug trial that is exempt from having such an investigational new drug application.

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

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

For clinical trials, routine patient costs do not include—

1. the investigational item, device, or service, itself;
2. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
3. costs for the management of research relating to the clinical trial or study;
4. any portion of the clinical trial or study that is paid for by a government or a bio-technical, pharmaceutical, or medical industry;
5. coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
6. extraneous expenses related to participation in the clinical trial; or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur.

If one or more in-network providers are participating in a clinical trial, Cigna may require that an Insured residing in Tennessee participate in the trial through a Tennessee participating in-network provider if that provider is willing to accept the Insured as a participant in the trial.

Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level only if the clinical trial is conducted outside the Insured's state of residence. A non-participating provider located in the Insured's state of residence will be reimbursed at the rate that the Insured's plan would otherwise pay a non-participating provider for covered services.

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 and education, 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.

Treatment Received from Foreign Country Providers

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

Cigna does not accept assignment of benefits from Foreign Country Providers. You and Your Family Member can file a claim with Cigna for services and supplies from a Foreign Country Provider 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.

Telehealth/Telemedicine Medical Services

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

Home Health Care

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

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 a combined maximum number of visits each Year as shown in the Benefit Schedule.** If the Insured Person is a minor or an adult who is dependent upon others for nonskilled care, custodial services and/or activities of daily living (e.g., bathing, eating, etc.), Home Health Care will be covered only during times when there is a family member or care giver present in the home to meet the Insured Person's nonskilled care and/or custodial services needs. Covered Services are limited to patient care that is determined to be Medically Necessary by Us. For purposes of this provision a Home Health Care visit is defined as up to 2 hours of Medically Necessary care per visit, with a maximum of 8 visits per day, and prescribed by a Physician in lieu of hospitalization. Home Health Care Services must be provided by one of the following providers:

- Services of a registered nurse.
- Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.

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

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

Smoking Cessation

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

Injury While Intoxicated or Under the Influence of a Narcotic

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

This Policy provides benefits for Covered Expenses incurred as a result of and related to an injury sustained while an insured is either intoxicated or under the influence of a narcotic, regardless of the conditions under which the substance is administered by or under the advice of a Physician.

Mastectomy and Related Procedures

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

This Policy provides benefits for Covered Expenses for hospital and professional services under this Policy for mastectomy and lymph node dissection for the treatment of breast cancer and for the treatment of physical complications of all stages of mastectomy, including lymphedema, whether or not the mastectomy occurred while the Insured Person was covered under this Policy. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. 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 Temporomandibular Joint Dysfunction (TMJ)

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

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, including TMJ.

Phenylketonuria Treatment

Benefits are payable for charges for the treatment by licensed professional medical services under a Physician's supervision of phenylketonuria (PKU) including special dietary formulas which are Medically Necessary for therapeutic treatment. Special dietary formulas are covered under the Prescription Drug benefit.

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 prescriptions which are necessary for the alleviation or correction of Injury, Illness 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.

Exclusions And Limitations: What Is Not Covered By This Policy

Excluded Services

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

- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed** as Covered Services in this Policy.
- Services or supplies that are **not Medically Necessary**.
- Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures.** This does not apply to an Insured Person participating in a Clinical Trial as specifically stated in the sections of this Policy titled "Clinical Trials", "Clinical Trial Costs" and "Off Label Drugs".
- Services received **before the Effective Date** of coverage.
- Services received **after coverage under this Policy ends**.
- Services for which You have **no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage. This does not apply to services rendered by a non-governmental charitable research hospital which does not enforce, by judicial proceedings, collection from individual patients in the absence of insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any **workers' compensation, employer's liability law or occupational disease law,** even if the Insured Person does not claim those benefits.
- Conditions caused by: (a) an **act of war (declared or un-declared)**; (b) the **inadvertent release of nuclear energy** when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person **participating in the military service of any country**; (d) an Insured Person **participating in an insurrection, rebellion, or riot**; (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a **felony** (whether or not charged) **or as a direct result of the Insured Person being engaged in an illegal occupation**; (f) an Insured Person being intoxicated, as defined by applicable state law in the state where the illness occurred or under the influence of illegal narcotics or non-prescribed controlled substances unless administered or prescribed by Physician.
- Any **services provided by a local, state or federal government agency,** except (a) when payment under this Policy is expressly required by federal or state law.
- Any **services required by state or federal law** to be supplied by a public school system or school district.
- Any **services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- **If the Insured Person is eligible for Medicare** Part A, B or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
- **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Professional **services or supplies received or purchased directly or on Your behalf by anyone, including a Physician**, from any of the following:
  - Yourself or Your employer;
  - a person who lives in the Insured Person's home, or that person's employer;
  - a person who is related to the Insured Person by blood, marriage or adoption, or that person's employer.
- **Custodial Care**.
- Inpatient or outpatient **services of a private duty nurse**.

- Inpatient room and board **charges in connection with a Hospital stay primarily for environmental change or physical therapy; Custodial Care or rest cures**; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
- **Assistance in activities of daily living**, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or convalescent care.
- Inpatient room and board **charges in connection with a Hospital stay primarily for diagnostic tests** which could have been performed safely on an outpatient basis.
- **Dental services**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **Dental Implants**: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
- **Hearing aids**, including but not limited to: semi-implantable hearing devices, audiant bone conductors, Bone Anchored Hearing Aids (BAHAs), batteries, cords and other assistive devices such as FM systems, except as specifically stated in this policy.
- **Routine hearing tests** except as specifically provided under Preventive Care and Newborn Hearing Benefits.
- **Genetic screening** or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An **eye surgery solely for the purpose of correcting refractive defects** of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Outpatient **speech therapy**, except as specifically stated in this Policy.
- **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self esteem or to treat psychological or psychosocial complaints regarding one's appearance including macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; and blepharoplasty,. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
- **Aids or devices that assist with nonverbal communication**, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- **Non-Medical counseling or ancillary services**, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities and developmental delays.
- **Services for** redundant skin surgery, removal of skin tags, acupressure, acupuncture, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, **regardless of clinical indications**.
- Procedures, surgery or treatments **to change characteristics of the body to those of the opposite sex**, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery. This also includes any medical, surgical or psychiatric treatment or study related to **sex change**.
- Treatment of **sexual dysfunction** impotence and/or inadequacy except if this is a result of an Accidental Injury, organic cause, trauma, infection, or congenital disease or anomalies.

- All services related to **the evaluation or treatment of fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in this Plan.
- **Cryopreservation** of sperm or eggs or storage of sperm for artificial insemination (including donor fees).
- Charges in connection with elective abortions and medically necessary abortions unless the pregnancy is determined to be non-viable.
- All **non-prescription** Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription. **Injectable drugs** (self-injectable medications) **that do not require Physician supervision. All 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, except as provided in the Prescription Drug benefits of this Policy. **Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision**, except as otherwise stated in this Policy. Infusion and Injectable Specialty drugs include, but are **not** limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- **Fees associated with the collection or donation of blood or blood products,** except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- **Blood administration** for the purpose of general improvement in physical condition
- **Orthopedic shoes** (except when joined to braces), shoe inserts, foot orthotic devices except as required by law for diabetic patients.
- Services primarily for **weight reduction or treatment of obesity including morbid obesity**, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Insured Person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
- **Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition,** including those required by employment or government authority, physical exams required for or by an employer, or for school, or sports physicals, except as otherwise specifically stated in this Plan.
- **Therapy or treatment intended primarily to improve or maintain general physical condition** or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- **Telephone, e-mail, and Internet consultations** or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters, except as specifically stated in this Policy.
- **Items which are furnished primarily for personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.).
- **Massage Therapy.**
- **Educational services** except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.
- **Nutritional counseling** or food supplements, except as stated in this Policy.
- **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this Policy.

- **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and under 'Physical and/or Occupational Therapy/Medicine' in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **All Foreign Country Provider** charges are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **Growth Hormone Treatment** except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition. Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- **Routine foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet except as otherwise stated in this Policy.
- **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for **the services of a standby Physician.**
- Charges for **animal to human organ transplants.**
- **Claims received by Cigna after 15 months from the date service was rendered,** except in the event of a legal incapacity.

Prescription Drug Benefits

Pharmacy Payments

Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the annual medical Deductible and once the Deductible is satisfied, subject to any applicable Copays 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 at www.mycigna.com.

In the event that You request a "brand-name" drug that has a “generic” equivalent, You will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the “generic” Copay or Coinsurance shown in the Benefit Schedule.

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

- the Copay or Coinsurance for the Prescription Drug, or
- Cigna's discounted rate for the Prescription drug; or
- the Pharmacy’s Usual and Customary (U&C) charge for the Prescription Drug.

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

Covered Expenses

If the Insured Person(s), while 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

- Outpatient Drugs and medications that Federal and/or applicable law restrict to sale by Prescription only, except for Insulin which does not require a prescription.
- Pharmaceuticals to aid smoking cessation.
- Insulin (no prescription required); syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.
- Self-Administered Injectable Drugs, and syringes for the self-administration of those Drugs.
- Orally administered anti-cancer medications prescribed in connection with cancer chemotherapy treatments.
- All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.
- Special dietary formulas which are Medically Necessary for therapeutic treatment of Phenylketonuria (PKU) or other inheritable diseases
- Contraceptive Drugs and devices approved by the FDA.
- Specialty Medications are covered.

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 (FDA); or if prescribed for off-label use, charges made for or in connection with a Drug that has been prescribed for the treatment of a type of condition for which it has not been approved by the FDA. Such Drug must be covered, provided:
  a. it is recognized as medically appropriate for the treatment of the specific type of condition for which the Drug has been prescribed in any one of the following reference compendia: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; United States Pharmacopeia Drug Information; or the drug is recommended by one review article in a U.S. peer-reviewed national professional journal;
  b. it has been otherwise approved by the FDA; and
  c. its use for the specific type of treatment prescribed has not been contraindicated by the FDA
- 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 the days supply indicated in the "Limitations" section below.
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification.

Exclusions

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

- Drugs not approved by the Food and Drug Administration;
- Drugs available over the counter that do not require a prescription by federal or state law except as otherwise stated in this Policy, or specifically required under the Patient Protection and Affordable Care Act (PPACA);
- Drugs that do not require a federal legend (a federal designation for drugs requiring supervision of a Physician), other than insulin;
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- Inectable or Infused infertility related drugs, except those required by the Patient Protection and Affordable Care Act (PPACA);
- 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;
- Any drugs that are Experimental or Investigational as described under the Medical "Exclusions" section of the Policy; except as specifically stated in the sections of this Policy titled "Clinical Trials", "Clinical Trial Costs" and "Off Label Drugs";
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals;
- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies; except for those pertaining to Diabetic Supplies and Equipment;
- Implantable contraceptive products inserted by the Physician are covered under the Plan's medical benefits;

- Prescription vitamins (other than prenatal vitamins), dietary supplements, herbal supplements and flouride, other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);
- Drugs used for cosmetic purposes that have no medically acceptable use, such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or Fractions are covered under the medical benefits of this Policy;
- Medications used for travel prophylaxis, except anti-malarial drugs;
- Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured's condition; growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Drugs obtained outside the United States;
- Replacement of Prescription Drugs and Related Supplies due to loss or theft;
- Drugs used to enhance athletic performance;
- Drugs which are to be taken by or administered to the Insured Person while a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- Prescriptions more than one year from the original date of issue.

Limitations

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

- Up to a consecutive 90-day supply, at a retail Pharmacy for Preferred Generic, Non-Preferred Generic, Preferred Brand and Non-Preferred Brand and Up to a 30-day supply of Specialty medications, unless limited by the drug manufacturer's packaging: or
- Up to a 90-day supply at a mail-order Pharmacy for Preferred Generic, Non-Preferred Generic, Preferred Brand and Non-Preferred Brand and Up to a 30-day supply of Specialty medications, unless limited by the drug manufacturer's packaging; or
- Tobacco cessation medications that are included on Cigna's Prescription Drug List are limited to two 90-day supplies per Year.
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification.
- 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.
- To a dosage and/or dispensing limit as determined by the P&T Committee.

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

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

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

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

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

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

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.

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

Claims and Customer Service

Drug claim forms are available upon written request to:

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

For Mail-order Pharmacy claims:

Cigna Home Delivery Pharmacy
P.O. Box 1019
Horsham PA 19044-1019

Forms are also available online at www.myCigna.com.

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

Pediatric Vision Services Performed by an Ophthalmologist or Optometrist

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

Definitions

Pediatric Frame Collection means designated frames, that are adequate to hold lenses, and are covered in full under essential healthcare benefits.

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

Pediatric Vision Benefits

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

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

What's Covered

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

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

Some Cigna Vision Network Eye Care Professionals may not offer these services. Please check with your eye care professional first before scheduling an appointment.

Exclusions

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

Limitations

No payment will be made for 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:

- medical or surgical treatment of the eye;
- lenses which are not medically necessary and are not prescribed by an Optometrist or Ophthalmologist, or frames for such lenses;
- care not listed in The Schedule;
- Other Exclusions and Limitations listed in this Policy

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

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

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
PO Box 385018
Birmingham, AL 35238-5018

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

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

General Provisions

Expenses For Which A Third Party May be Liable

If you incur a Covered Expense for which, in Our opinion, another party may be liable We shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party for medical expenses and shall automatically have a lien upon the proceeds designated for medical expense of any recovery by judgement, settlement or award by you from such party to the extent of any benefits paid for such expenses under the Policy. You or your representative shall execute such documents as may be required to secure Our subrogation rights.

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.

Other Insurance

The Insured Person may have Other Valid Coverage (with another insurer) which applies to a loss covered by this Policy. Other Valid Coverage may reduce the benefits payable under this Policy. The benefits payable under this Policy will not be reduced by Other Valid Coverage if the Insured Person has notified Us in writing that they do have Other Valid Coverage. The Insured Person must notify Us before a loss begins. The benefits payable under this Policy will be reduced by Other Valid Coverage if the Insured Person has not notified Us in writing (before the loss begins) that the Insured Person does have Other Valid Coverage. The amount of he reduced benefits payable under this Policy will be determined by applying the formula below:

ADD: The benefit which would have been payable under this Policy,

PLUS: The total of the like benefits under all Other Valid Coverage's on the same loss of which We have had notice,

DIVIDED BY: The total like benefits under all valid coverage's for such loss.

When benefits are reduced due to Other Valid Coverage, We will return part of the last premium paid prior to the commencement of a loss covered under this Policy. The proportion We will use to determine the premium refund will be the same proportion We use to determine the benefit reduction in the formula above.

When Other Valid Coverage is written on a provision of service basis, the "like amount" of such other coverage will mean the dollar amount which the services received would have cost if the Insured Person did not have the other 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.

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.

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

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

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

Start with Customer Service

We are here to listen and help. If an Insured Person has a concern regarding a person, a service, the quality of care, an initial eligibility denial, a rescission of coverage, or contractual benefits, you can call our toll-free number and explain the concern to one of Our Customer Service representatives. Please call Cigna at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits, or claim form.

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

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

Appeals Procedure

To initiate an appeal, the Insured Person must submit a request for an appeal in writing, within 180 days of receipt of the denial notice, to the following address:

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

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

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

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

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

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

Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

If the Insured Person is not satisfied with Cigna's decision regarding eligibility of an expedited external review, the Insured Person may file a complaint with the Commissioner's office. The Commissioner may make a different determination regarding the Insured Person's eligibility for an expedited external review. The Commissioner's office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Independent Review Procedure

If the Insured Person is not fully satisfied with the decision of Cigna's appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant's rights to any other benefits under the Policy.

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

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a determination by Cigna regarding Medical Necessity, clinical appropriateness, healthcare setting, level of care, or effectiveness of the service or treatment the Insured Person requested. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, the Insured Person must notify the Appeals Coordinator within 180 days of the Insured Person's receipt of Cigna's appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if (a) a delay would be detrimental to the Insured Person's condition, as determined by Cigna's Physician reviewer, or if (b) the Insured Person's appeal concerns an admission, availability of care, continued stay, or health care item or service for which the Insured Person received emergency services, but the Insured Person has not yet been discharged from the facility, the review shall be completed within 72 hours.

If the Insured Person is not satisfied with Cigna's decision regarding eligibility for an expedited external review, the Insured Person may file a complaint with the Commissioner's office. The Commissioner may make a different determination regarding the Insured Person's eligibility for an expedited external review. The Commissioner's office may be contacted at the address and telephone number given below for an Appeal to the State of Tennessee.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) 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.

Dispute Resolution

All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Our grievance procedures. Grievances may be reported by telephone or in writing. All grievances received by Us that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Insured Person and Us will be acknowledged in writing, along with a description of how We propose to resolve the grievance.

Binding Arbitration

To the extent permitted by law, any controversy between Cigna and an insured (including any legal representative acting on Your behalf), arising out of or in connection with this Policy may be submitted to binding arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Policy shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Policy pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Policy.

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.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except intentional, fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

Class Action Waiver: Except as provided by Tennessee, 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 Tennessee; 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.

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

If You did not purchase Your Plan from a state based, partnership or federal facilitated marketplace, or elect to not receive advanced premium tax credit, there is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period unless We notify the Insured Person at the billing address listed in Our records at least 30 days prior to any premium due date that We do not intend to renew this Policy, or the Insured Person notifies Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period for plans not purchased from the marketplace or the 61 day grace period for plans purchased from a state or federal marketplace.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception, or intentional misrepresentation of material fact in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in your class. In this event, Tennessee 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 Tennessee, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. When the Insured no longer lives in the Service Area.

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

Modification of Coverage: We reserve the right to modify this policy, including Policy provisions, benefits and coverages, so long as such modification is consistent with state or federal law and effective on a uniform basis among all individuals with coverage under this same Policy form. We will only modify this Policy for all Insured Persons in the same class and covered under the same Policy form, and not just on an individual basis. We will send written notice and the change will become effective on the date shown in the notice or on the next scheduled premium due date thereafter. Payment of the premiums will indicate acceptance of the change.

Member Services/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.

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 and give You a conditional receipt for Your late premium payment, We will only reinstate this Policy if either We approve Your reinstatement application, or lacking such approval, upon the forty-fifth day following the date on Our conditional receipt if We have not by that date notified You in writing of Our disapproval of Your application.

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

Renewal: This Policy renews on a Calendar Year basis.

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

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person. Adjustment of premium rate will be in effect going forward from the date of notification of the change and will not be retroactive.

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-Tennessee
P.O. Box 30365
Tampa, FL 33630-3365
1-877-484-5967

- When an overpayment has been made by US, WE will have the right within 18 months to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment. WE will have the right to recover an overpayment at any time if the insured does not provide complete information, was not eligible for coverage or when material mistakes or fraud have occurred.

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

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

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

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

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

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

  - Ongoing treatment of an Insured Person up to the 90th day from the date of the provider's termination date.
  - Ongoing treatment of an Insured Person who at the time of termination has been diagnosed with a terminal illness, but in no event beyond 9 months from the date of the provider's termination date.

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

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

- Failure by Cigna to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.

- If Insured Person(s) were **covered by a prior Individual Cigna Policy** that is replaced by this Policy with no lapse of coverage, benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer

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.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

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

Changing Primary Care Physicians:

The Insured Person may request a transfer from one Primary Care Physician to another by contacting Us at the member services number on ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.
In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, The Insured Person will be notified for the purpose of selecting a new Primary Care Physician, if they choose.

How to File a Claim for Benefits

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

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

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

Claim Reminders:

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

Proof of Loss: You must give Us written proof of loss within 18 months after the date of the loss, except in absence of legal capacity. Proof of loss is a claim form as described above. Canceled checks or receipts are not acceptable. Cigna will not be liable for benefits if it does not receive written proof of loss within this time period.

Assignment of Claim Payments:

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

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. 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

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

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

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

Time Payment of Claims: All claims and indemnities payable under the terms of this Policy shall be paid immediately following written receipt by Us of due proof of loss.

Claim Determination Procedures Under Federal Law (Provisions of the laws of this state 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 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify the Insured Person or their representative within 15 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date the Insured Person or their representative responds to the notice.

If the determination periods above would (a) seriously jeopardize the Insured Person's life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Insured Person's health condition, cause them severe pain which cannot be managed without the requested services, Cigna will make the pre-service determination on an expedited basis. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if 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 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the Insured Person or their representative requests written notification.

Concurrent Medical Necessity Determinations

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

Post-service Medical Necessity Determinations

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

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

Post-service Claim Determinations

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

Notice of Adverse Determination

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

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

Premiums

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

Cigna also reserves the right to change the premium on 30 days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Insured Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown on the notice, and payment of the new premiums will indicate acceptance of the change.

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