Cigna Health and Life Insurance Company ("Cigna")

Cigna FocusIn Flex Silver 4000

Your medical coverage is provided under a Policy issued by Cigna Health and Life Insurance Company (Cigna), an insurance company licensed to conduct business and provide individual and family major medical health plans in the state of Texas.

OUTLINE OF COVERAGE / WRITTEN PLAN DESCRIPTION

Section I.

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

Note: This exclusive provider benefit plan does not cover services You receive from Out-of-Network Providers, **except** services for treatment of an Emergency Medical condition, or Medically Necessary care that is not available through an In-Network Provider. You are responsible for paying any charges from Out-of-Network providers that this plan does not cover.

If You wish to contact Cigna for any reason, use the address and/or phone number below:

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

An In-Network, or 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 by type of Provider—for example, a Participating Hospital or Participating Physician.

An Out-of-Network, or Non-Participating 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. You will be financially responsible for any Non-Emergency Services You receive from an Out-of-Network provider. .

IMPORTANT NOTICES:

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

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

NOTICE OF RIGHTS UNDER A EXCLUSIVE PROVIDER PLAN (EPO)

An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.

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

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

If your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the non-preferred provider's bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts.

You may obtain a current directory of preferred providers at the following website: mycigna.com or by calling the toll free number on the back of your ID card for assistance in finding available preferred providers. If you relied on materially inaccurate directory information, you may be entitled to have an out-of network claim paid at the in-network level of benefits.

BENEFIT SCHEDULE

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

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

Services for Out-of-Network providers are not covered except for initial care to treat and stabilize an Emergency Medical Condition. For additional details see the "How The Plan Works" section of Your Policy.

Note: This exclusive provider benefit plan does not cover services You receive from Out-of-Network Providers, **except** services for treatment of an Emergency Medical condition, or Medically Necessary care that is not available through an In-Network Provider. You are responsible for paying any charges from Out-of-Network providers that this plan does not cover.

BENEFIT INFORMATION **Note:** **Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.**	**IN-NETWORK PROVIDER (Based on Negotiated Rate)** **YOU PAY:**
Medical Benefits	
Annual Plan Deductible *Individual* *Family*	 $4,000 $8,000
Out-of-Pocket Maximum *Individual* *Family* The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties and Policy Maximums	 $6,700 $13,400 .
Coinsurance	You and Your Family Members pay 30% of Charges after the plan Deductible.

Benefit Schedule Form Number:
INDTXEPOBNFTSCH042015

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.	IN-NETWORK PROVIDER (Based on Negotiated Rate) YOU PAY:
Prior Authorization Program **Prior Authorization – Inpatient Services** **Prior Authorization – Outpatient Services** **NOTE:** Please refer to the section on Prior Authorization of inpatient and outpatient services for more information in You Policy. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of Your ID card or at www.mycigna.com under "View Medical Benefits Details".	Your Participating Provider must obtain approval for inpatient admissions; or Your Provider's payment may be reduced by the lesser of 50% or a $500 penalty for non-compliance. **You are not responsible for this penalty.** Your Participating Provider must obtain approval for certain outpatient procedures and services; or Your Provider's payment may be reduced by the lesser of 50% or $60 penalty for non-compliance. **You are not responsible for this penalty.**
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
Pediatric Vision Care Performed by an Ophthalmologist or Optometrist for a Member who is under age 19. Please be aware that not all contracted vision care providers provide all vision care services as part of their practice. Please check with the provider to verify that he or she offers the services you wish to receive under his/her Cigna participating provider agreement. **Comprehensive Eye Exam** (Limited to one exam per year) **Pediatric Frames for Children** (Limited to one pair per year) **Eyeglass Lenses for Children** (Limited to one pair per year) Single Vision, Lined Bifocal, Lined Trifocal Lenticular **Contact Lenses and Professional Services for Children** (Limited to one pair per year) **Elective** **Therapeutic** **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	0% Deductible waived 0% Deductible waived 0% Deductible waived 0% Deductible waived 0% Deductible waived

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.	IN-NETWORK PROVIDER (Based on Negotiated Rate) YOU PAY:
Physician Services **Office Visit** ***Primary Care Physician (PCP)*** ***Specialist Physician*** *(including consultant, referral and second opinion services)* ***NOTE:*** *if a Copayment applies for OB/GYN visits, the level of Copayment You pay will depend on how Your doctor is listed in the provider directory*	 $20 Copayment Deductible waived $60 Copayment Deductible waived
Physician Services, continued Surgery in Physician's office Outpatient Professional Fees for Surgery (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy) Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy In-hospital visits Allergy testing and treatment/injections	 30% 30% 30% 30% 30%
Cardiovascular Disease Screenings Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details and limitations.	0% Deductible waived
Hospital Services **Inpatient Hospital Services** Facility Charges Professional Charges **Emergency Admissions**	 30% 30% Benefits are shown in the Emergency Services Schedule on page 10.
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	30%

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.	IN-NETWORK PROVIDER (Based on Negotiated Rate) YOU PAY:
Advanced Radiological Imaging (including MRIs, MRAs, CAT Scans, PET Scans) Facility and interpretation charges	30%
All Other Laboratory and Radiology Services Facility and interpretation charges Physician's Office Free-standing/Independent lab or x-ray facility Outpatient hospital lab or x-ray	 30% 30% 30%
Short-Term Rehabilitative Services Physical, Occupational, Chiropractic Therapy Maximum of 35 visits per Insured Person, per Calendar Year for all therapies. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders	30%
Cardiac & Pulmonary Rehabilitation Maximum of 36 visits per Insured Person, per Calendar Year. Limits based on Medical Necessity guidelines.	30%
Treatment of Temporomandibular Joint Dysfunction / Orthognathic Surgery (TMJ/TMD)	30%
Habilitative Services Maximum of 35 visits per Insured Person, per calendar year for all therapies. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders	30%
Womens' Contraceptive Services, Family Planning and Sterilization	$0 Deductible waived
Male Sterilization	Copay or Coinsurance applies for specific benefit provided

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.	IN-NETWORK PROVIDER (Based on Negotiated Rate) YOU PAY:
Maternity (Pregnancy and Delivery)	
Initial Office Visit to confirm pregnancy and subsequent prenatal visits billed separately from the "global" fee	PCP or Specialist Office visit benefit applies
Prenatal services, Postnatal and Delivery (billed as "global" fee)	30%
Hospital Delivery charges	30%
Prenatal testing or treatment billed separately from "global" fee	30%
Postnatal visit or treatment billed separately from "global" fee	PCP or Specialist Office visit benefit applies
Dialysis	
Inpatient	Inpatient Hospital Services benefit applies
Outpatient	30%
Autism Spectrum Disorders	
Diagnosis of Autism Spectrum Disorder Office Visit	PCP or Specialist Office Visit benefit applies
Diagnostic testing	30%
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
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 25 days per Insured Person, per Calendar Year for all facilities listed.	30%
Home Health Services Maximum 60 visits per Insured Person, per Calendar Year. Maximum 16 hours per day / Maximum 4 visits per day	30%

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.	IN-NETWORK PROVIDER (Based on Negotiated Rate) YOU PAY:
External Prosthetic Appliances	30%
Durable Medical Equipment	30%
Hospice	
Inpatient	30%
Outpatient	30%
Newborn/Infant Hearing Screening	0% Deductible waived
Speech and Hearing	
Restore loss of or correct an impaired speech or hearing function	30%
Maximum of 1 hearing aid per ear every 3 years per Insured Person	30%
Mental, Emotional, Functional Nervous Disorders and Serious Mental Illness	
Inpatient (Includes Acute and Residential Treatment)	30%
Outpatient (Includes individual, group, intensive outpatient and partial hospitalization)	
Office Visit	$60 Copayment Deductible waived
All other outpatient services	30%
Substance Use Disorder	
Inpatient Detoxification/Rehabilitation (Includes Acute and Residential Treatment)	30%
Outpatient (Includes individual, group, intensive outpatient and partial hospitalization)	
Office Visit	$60 Copayment Deductible waived
All other outpatient services	30%

BENEFIT INFORMATION Note: Covered Services are subject to Annual and any additional deductible(s) unless specifically waived.	IN-NETWORK PROVIDER (Based on Negotiated Rate) YOU PAY:
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** **Other Cigna Network Facility** **Out-of-Network Facility**	 0% 30% NOT APPLICABLE
Infusion and Injectable Specialty Prescription Medications and related services or supplies	30%
Dental Care Limited to treatment for accidental injury to natural teeth within twenty-four months of the accidental injury	30%

Emergency Services *(Note: This Plan covers Emergency Services from In- and Out-of-Network Providers as shown:*	*What You Pay* For **Participating Providers** based on the Cigna Negotiated Rate	*What You Pay* For **Non-Participating Providers** based on the Maximum Reimbursable Amount
Emergency Services –		
Hospital Emergency Room	30%	In-network benefit level for an Emergency Medical Condition only, otherwise Not Covered
Urgent Care Services	$75 Copayment per visit Deductible waived	In-network benefit level for an Emergency Medical Condition only, otherwise Not Covered
Ambulance Services Note: coverage for Medically Necessary transport to the nearest facility capable of handling an Emergency Medical Condition.		
Emergency Transport	30%	In-network benefit level for an Emergency Medical Condition only, otherwise Not Covered
Non-Emergency Transport	Not Covered	Not Covered
Inpatient Hospital Services (for emergency admission to an acute care Hospital)		
Hospital Facility Charges	30%	In-Network benefit level until transferable to an In-Network Hospital; if not transferred then Not Covered
Professional Services	30%	In-Network benefit level until transferable to an In-Network Hospital; if not transferred then Not Covered

PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY YOU PAY AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	CIGNA HOME DELIVERY PHARMACY YOU PAY 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 Percentage Copayment shown in the Benefit Schedule.		
	Cigna Retail Pharmacy Drug Program YOU PAY PER PRESCRIPTION OR REFILL:	**Cigna Mail Order Pharmacy Drug Program YOU PAY PER PRESCRIPTION OR REFILL:**
Tier 1: Preferred Generic	$4 Copay per Prescription or refill Deductible waived (Up to a 90 day maximum supply. For Copay Plans, You pay a Copay for each 30-day supply)	$10 Copay per Prescription or refill Deductible waived (Up to a 90 day maximum supply)
Tier 2: Non-Preferred Generic	$15 Copay per Prescription or refill Deductible waived (Up to a 90 day maximum supply. For Copay Plans, You pay a Copay for each 30-day supply)	$37 Copay per Prescription or refill Deductible waived (Up to a 90 day maximum supply)
Tier 3: Preferred Brand	$50 Copay per Prescription or refill Deductible waived (Up to a 90 day maximum supply. For Copay Plans, You pay a Copay for each 30-day supply)	$125 Copay per Prescription or refill Deductible waived (Up to a 90 day maximum supply)
Tier 4: Non-Preferred Brand	50% per Prescription or refill (Up to a 90 day maximum supply)	50% per Prescription or refill (Up to a 90 day maximum supply)
Tier 5: Specialty generic and brand name medications that meet the criteria of specialty drugs	$550 Copay per Prescription or refill Deductible waived (Up to a 30 day maximum supply)	$475 Copay per Prescription or refill Deductible waived (Up to a 30 day maximum supply)
Preventive Drugs regardless of Tier Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including women's contraceptives) that are: ▪ Prescribed by a Physician ▪ Generic or Brand Name with no Generic alternative Up to a 90 day maximum supply	0% Deductible waived per Prescription or refill	0% Deductible waived per Prescription or refill

Section II.

Emergency Services and Benefits

Cigna is obligated to provide reimbursement for emergency care at the Participating Provider level if the Insured Person cannot reasonably reach a Participating Provider and until the Insured Person can reasonably be expected to transfer to a Participating Provider.

The emergency care services subject to this section include:

1. any medical screening examination or evaluation required by state or federal law to be provided in the emergency department of a Hospital necessary to determine whether a medical emergency exists;
2. necessary emergency care services including the treatment and stabilization of an Emergency Medical Condition; and
3. services originating in a Hospital emergency department following treatment or stabilization of an Emergency Medical Condition.

After Hours Care

In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or Your local emergency service, police or fire department for help.

If an Illness or Injury occurs outside of Your doctor's normal office hours, use Your judgment regarding the level of treatment You require. For less severe conditions You can call Your doctor's answering service to speak to Your doctor or a doctor who is on call for Your doctor. You can also call the Cigna HealthCare 24-Hour Health Information Line SM for further assistance and advice on follow-up care.

Section III.

Out of Area Services and Benefits

If an unforeseen Illness or Injury occurs during an Insured Person's temporary absence from the Service Area and health care services cannot be delayed until the Insured Person's return to the Service Area, benefits for Medically Necessary services will be reimbursed at the Participating Provider level.

Section IV.

Insured's Financial Responsibility

The Insured is responsible for paying the monthly or quarterly premium on a timely basis. The Insured is also responsible to pay Providers for charges that are applied to the Deductibles, Coinsurance, Copayment, and Penalties. In addition, any charges for Medically Necessary items that are excluded under this Policy are the responsibility of the Insured. Charges for an Out-of-Network (Non-Participating Provider), except for Emergency Services, are excluded from coverage under this Policy and are the responsibility of the Insured.

Special Limits

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

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

Section V.

Exclusions, Limitations, and Reductions

A. The Participating Provider Plan does not provide benefits for:

● Services obtained from an Out-of-Network (Non-Participating) Provider, except for Emergency Services (including those provided by an Urgent Care facility) ●Any **amounts in excess of maximum amounts of Covered Expenses**. ● Services **not specifically listed** as Covered Services. ● Services or supplies that are **not Medically Necessary; however You have the right to appeal an adverse determination regarding medical necessity**. ●Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures; however You the right to appeal an adverse determination regarding experimental procedures or investigative procedures**. ● Services received **before the Effective Date** of coverage. ● Services received **after coverage ends; except for treatment approved under the Continuity of Care provision**. ● Services for which You have **no legal obligation to pay** or for which no charge would be made if You did not have a health plan or insurance coverage, except to the extent that the availability of insurance or health plan coverage may be considered by a tax supported institution of the State of Texas providing treatment of mental Illness or mental retardation to determine if a patient is non-indigent, as provided in Article 3196a of Vernon's Texas Civil Statutes.● Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any **workers' compensation**, employer's liability law or occupational disease law, even if the Insured Person does not claim those benefits. ● Conditions caused by: (a) an **act of war (declared or un-declared);** (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the **military service** of any country; (d) an Insured Person participating in an **insurrection, rebellion, or riot;** (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a **felony** (whether or not charged) **or as a direct result of the Insured Person being engaged in an illegal occupation;** ● Any services provided by a local, state or federal **government agency,** except when payment under the Policy is expressly required by federal or state law or services provided for the treatment of mental or nervous disorders by a tax supported institution of the State of Texas. ● Any services required by state or federal law to be supplied by a public school system or school district. ● If the Insured Person is eligible for Medicare part A, B or D, CIGNA will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount CIGNA would have paid if it were the sole insurance carrier. ● Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as cover in the plan ● Any services for which payment may be obtained from any local, state or federal **government agency** (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current

legislation. ● Professional **services or supplies received or purchased directly or on Your behalf by anyone, including a Physician,** from any of the following: Yourself or Your employer; a person who lives in the Insured Person's home, or that person's employer; a person who is related to the Insured Person by blood, marriage or adoption, or that person's employer. This does not apply to covered dental services provided by a dentist licensed in the state of Texas and operating within the scope of his or her licensure. ● Custodial Care. ● **Private duty nurse, except as specifically stated under Home Health Care**. ● 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 the Policy. ● **Orthodontic services**, braces and other orthodontic appliances including orthodontic services for temporomandibular joint dysfunction. ● **Dental implants**: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants. ● **Hearing aids** , except as specifically stated in the Policy. ● Routine **hearing tests** except as specifically provided under "Comprehensive Benefits, What the Plan Pays For. ● Genetic screening or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease. ● **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in the 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). ● Any **drugs**, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in the Policy. This includes, but is not limited to, items dispensed by a Physician. ● **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 abdominoplasty/panniculectomy; rhinoplasty. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by injury or congenital defect of a newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy. ● Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery. This also includes any medical, surgical or psychiatric treatment or study related to **sex change**. ● Aids or devices that assist with nonverbal communication, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books except as specifically stated in this Policy. ● Non-Medical counseling or ancillary services, including but not limited to; education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities and developmental delays. ● Services for redundant skin surgery, removal of skin tags, acupressure, acupuncture carinosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications. ● Treatment of **sexual dysfunction** impotence and/or inadequacy ● All services related to the evaluation or treatment of **fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive,

medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) except as specifically stated in this Policy. ● All non-prescription Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription; Injectable drugs ("self-injectable medications) that do not require Physician supervision; All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, and Self-administered Injectable Drugs, except as stated in the Benefit Schedule and in the Prescription Drug Benefits Schedule. ● Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision, except as otherwise stated in the 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.** ● **Cryopreservation** of sperm or eggs or storage of sperm for artificial insemination (including donor fees). ● **Orthopedic shoes** (except when joined to braces) or shoe inserts, foot orthotic devices including orthotics except as specifically stated under External Prosthetic Appliances and Devices in the Benefits section of this Policy. ● Services primarily for **weight reduction** or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Insured Person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction. ● **Routine physical exams or tests** that do not directly treat an actual Illness, Injury or condition, including those required by employment or government authority, physical exams required for or by an employer, or for school, or sports physicals, except as otherwise specifically stated in this Plan. ● Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected. ● Items which are furnished primarily for **personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.). ● **Massage therapy** ● **Educational services** except for diabetes self-management training programs and those offered by Cigna. ● **Nutritional counseling** or food supplements, except as specifically listed in the Policy. ● **Durable Medical Equipment** not specifically listed as Covered Services in the Policy. Excluded Durable Medical Equipment includes, but is not limited to: orthopedic shoes or shoe inserts (except as specifically stated under External Prosthetic Appliances and Devices in the Benefits section of the Policy),; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as stated under Diabetes treatment or otherwise stated in this Policy. ● **Self-administered injectable drugs**, except as stated in the Benefit Schedule and in the Prescription Drug Benefits section of the Policy ● Any Drugs, medication, or other substances dispensed or administered in any outpatient setting except as specifically stated in the Policy. This includes, but is not limited to, items dispensed by a Physician ● **All Foreign Country Provider** charges are excluded under this Policy except as specifically stated under Treatment received from Foreign Country Providers under the Benefits section of the Policy. ● **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. ● **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.

B. The Participating Provider Plan does not provide Prescription Drug Benefits for:

- 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 the Policy, or specifically required under the Patient Protection and Affordable Care Act (PPACA);
- Drugs that do not require a Federal legend (a Federal designation for drugs requiring supervision of a Physician), other than insulin;
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee; except for prescription contraceptives and tobacco cessation drugs;
- Infertility related drugs; except those required by Patient Protection and Affordable Care Act (PPACA);
- Injectable 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;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug, and the medically necessary services associated with the administration of the drug, are recognized as safe and effective for the treatment of the Member's specific cancer in at least one standard medical reference compendia or medical literature. Standard medical reference compendia include: The American hospital formulary service drug information; The National Comprehensive Cancer Network Drugs and Biologics Compendium; Thomson Micromedex Compendium DrugDex, Elsevier Gold Standard's Clinical Pharmacology Compendium; Other Authoritative Compendia as identified by the Secretary of the United States Department of Health and Human Services;
- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies; except for those pertaining to Diabetic Supplies and Equipment;

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

C. The Participating Provider Plan limits Prescription Drug Benefits for:

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

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

D. The Participating Provider Plan does not provide Pediatric Vision Benefits for:

- 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.

E. The Participating Provider Plan limits Pediatric Vision Benefits for:

- No payment will be made for expenses incurred for:
- more than one examination and one pair of lenses during a calendar year; or more than one pair of frames during a calendar year for any one person.
- medical or surgical treatment of the eye;
- lenses which are not medically necessary and are not prescribed by an Optometrist, Therapeutic Optometrist or Ophthalmologist, or frames for such lenses;
- care not listed in The Schedule;

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 your Employer.

Section VI.

Prior Authorization Program

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

PRIOR AUTHORIZATION FOR INPATIENT SERVICES

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

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

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

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

Please note that emergency admissions will be reviewed post admission.

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

PRIOR AUTHORIZATION OF OUTPATIENT SERVICES

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

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

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

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

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

Retrospective Review

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

Prior Authorization—Prescription Drugs: Coverage for certain Prescription Drugs and Related Supplies 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.

Section VII.

Penalties

A Penalty is an amount of Covered Expenses that is:

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

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

Penalties will apply under the following circumstances:

- Inpatient Hospital admissions may be subject to a Penalty if You or Your Provider fail to obtain Prior Authorization.
- Free Standing Outpatient Surgical Facility Services may be subject to a Penalty per admission, if You or Your Provider fail to obtain Prior Authorization.

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

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

Section VIII.

Continuity Of Care

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

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

Section IX.

Complaint Resolution Procedures

WHEN YOU HAVE A COMPLAINT OR AN ADVERSE DETERMINATION 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.

The Plan may not engage in retaliatory action, including refusal to renew or cancellation of coverage, against the Insured Person because the Insured Person, or a person acting on behalf of the Insured

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

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

When You Have a Complaint

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

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

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

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

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

When a complaint is expedited, we will respond orally with a decision within the earlier of; 72 hours; or one working day, followed up in writing within 3 calendar days.

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

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

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

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

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

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

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

The Insured Person may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize the Insured Person's life, health or ability to regain maximum function or in the opinion of his or her Physician would cause severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna’s Physician reviewer, in consultation with the treating

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

When You have an Adverse Determination Appeal

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

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

If the time frames under this process would (a) seriously jeopardize the Insured Person's life, health or ability to regain maximum function or (b) in the opinion of his Physician would cause severe pain which cannot be managed without the requested services; or if the appeal involves non-authorization of an admission or continuing inpatient Hospital stay, Insured Persons are eligible for an expedited appeal process The expedited appeal must be completed based on the immediacy of the medical or dental condition, procedure, or treatment, and cannot exceed one working day from the date all information necessary to complete the appeal is received. Also an expedited appeal determination may be provided by telephone or electronic transmission, but must be followed with a letter within three working days of the initial telephone or electronic notification.

If you request that your appeal be expedited because time frames under this process would seriously jeopardize Your life, health or ability to regain maximum function, or in the opinion of Your Physician would cause severe pain which cannot be managed without the requested services, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within the earlier of; 72 hours; or one working day, followed up in writing within 3 calendar days. If an Insured Person is not satisfied with the results of a coverage decision, they can start the complaint appeals procedure.

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

Independent Review Procedure

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

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

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

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

Appeal to the State of Texas

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

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

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the denial decision; (3) reference to the specific Policy provisions on which the decision is based; (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.

Section X.

Participating Providers

Cigna will provide a current list of physicians and other health care providers currently participating with Cigna and their locations to each Insured upon request.

To verify if a physician or other health care provider is currently participating with Cigna and is accepting new Cigna Insured's, the Insured should contact the Customer Service Unit at the number on the back of Your ID card, or visit our website, www.cigna.com.

Section XI.

Prescription Drug Formulary Information

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

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

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

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

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

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

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

Changes to Prescription Drug Formulary:

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

Section XI.

Service Area

Service Area is any place that is within the cities, counties and/or zip code areas in the state of Texas that Cigna has designated as the Service Area for this Plan. For specific information regarding Your Service Area, please check www.cigna.com/cignastatedirectory/cigna-in-texas or call 1.800.Cigna.24.

Network Demographics section

The number of insureds in Cigna's service area is 0. The numbers of available preferred providers in Cigna's service area for the following provider areas are indicated below:

Internal Medicine	1082
Family/General Practice	819
Pediatrics	719
Obstetrics and Gynecology	556
Anesthesiologists	825
Psychiatrists	281
General surgery	213

There are 108 preferred provider hospitals in Cigna's service area.

Waivers and Local Market Access Plan section

A waiver and local market access plan applies to the services provided by hospital services. This access plan may be obtained by contacting Insurance Cigna Health and Life Insurance Company at 1.800.Cigna.24 or at our website, http://hcpdirectory.cigna.com/web/public/providers.

Section XII.

Renewability, Eligibility, and Continuation

1. The Policy will renew on an annual basis except for the specific events stated in the Policy. Cigna may change the premiums of the Policy after 60 days written notice to the Insured. However, Cigna will not refuse to renew or change the premium schedule for the Policy on an individual basis, but only for all insured's in the same class and covered under the same Policy as You.
2. The Individual Plan is designed for residents of Texas who are not enrolled under or covered by any other group or individual health coverage. You must notify Cigna of all changes that may affect any Insured Person's eligibility under the Policy.
3. You or Your Insured Family Members will become ineligible for coverage:
    a. When premiums are not paid according to the due dates and grace periods described in the Premium section of the Policy.
    b. When the Insured's spouse is no longer married to the Insured.
    c. When the Insured Person no longer meets eligibility requirements as an eligible Family Member (except that grandchildren do not have to continue to qualify as a dependent of the Insured for federal income tax purposes).
4. If an Insured Person's eligibility under this Policy would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, that Member has the right to continuation of his or her insurance. Coverage will be continued if the Member exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Agreement would otherwise terminate. In such a case, coverage will continue without evidence of insurability.

Section XIII.

Premium

1. The initial premium for the Policy for which you have made application is $_____ for _____ months. Premiums thereafter are payable quarterly by check or monthly through automatic bank draft withdrawals. The initial premium amount must be submitted with your original application.
2. The premium rates for this Policy are based on the age, place of residence, and the number and relationship of the Insured's Family Member(s) covered by the Policy. Changes in these factors may result in a change in premium.
    a. The rate provided to You is for the residence shown in your application. It may not apply to a different place of residence. Your premium rates are subject to automatic adjustment upon change of residence.
    b. Cigna also has the right to change premiums after a 60 day notice to you.

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. 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.

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.