Cigna Health and Life Insurance Company
MAJOR MEDICAL EXPENSE COVERAGE

Cigna OAP 2750

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description 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!

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy. Basic hospital or basic hospital medical insurance coverage is not provided.
### Benefit Schedule Cigna OAP 2750

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN NETWORK YOU PAY</th>
<th>OUT OF NETWORK YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Individual Deductible</td>
<td>$2,750</td>
<td>$12,500</td>
</tr>
<tr>
<td>Annual Family Deductible</td>
<td>$5,500</td>
<td>$25,000</td>
</tr>
<tr>
<td><strong>All benefits listed below are subject to the Deductible unless otherwise noted</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cigna pays 85% of eligible charges for Physician services. You and Your Family Members pay 15% of Charges after the Annual Deductible.</td>
<td></td>
<td>Cigna pays 50% of eligible charges. You and Your Family Members pay 50% after the Annual Deductible.</td>
</tr>
<tr>
<td><strong>Individual Out of Pocket Maximum</strong></td>
<td>$7,000</td>
<td>$25,000</td>
</tr>
<tr>
<td><strong>Family Out of Pocket Maximum</strong></td>
<td>$14,000</td>
<td>$50,000</td>
</tr>
<tr>
<td><strong>The Following do not accumulate to the Out of Pocket Maximum: Penalties and Policy Maximums.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN NETWORK YOU PAY</th>
<th>OUT OF NETWORK YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(including allergy testing and treatment/injections and lab and x-ray tests done in the office)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>(including consultant, referral and second opinion services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Physician Services</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>and all In-Hospital Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>(in any setting)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Preventive Care

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>0% Deductible waived</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Preventive Well Care Services</strong></td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Babies/Children</strong></td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td>Office Visit</td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td>Flu shot, Immunizations, Routine Lab work, and testing</td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td>Hearing Screenings for Newborns</td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Adults and Children</strong></td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td>Office Visits/examination related to PSA, Annual OB/GYN Exam, Pap test, colorectal cancer screening (annual fecal occult blood test)</td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td>Routine Preventive Care (including Mammogram, PSA Screening, Pap Test, Colorectal Cancer Screening)</td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td>Note: for Breast Tomosynthesis done at a covered woman’s request in lieu of a screening mammogram, see benefit for All Other Laboratory and Radiology Services.</td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td>Routine Preventive Care to include immunizations, flu shots, and routine lab work and testing</td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Women’s Health Services</strong></td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td>Office visits and routine preventive care as shown above</td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td>Prenatal screening for anemia, gestational diabetes, hepatitis B, HIV, RH incompatibility, syphilis, urinary tract infections, tobacco use screening and counselling.</td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td><strong>All Other Routine Services</strong></td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td>Routine Physicals to include Immunizations, flu shots, and routing lab work and x-rays</td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
<tr>
<td>Please refer to “Comprehensive Benefits. What the Policy Pays For” section of this Policy for additional details</td>
<td>0% Deductible waived</td>
<td>50%</td>
</tr>
</tbody>
</table>
# EARLY INTERVENTION PROGRAM SERVICES

| Early Intervention Program Services | 0% Deductible waived | 0% Deductible waived |

## PEDIATRIC VISION CARE PERFORMED BY AN OPHTHALMOLOGIST OR OPTOMETRIST

For Insured Persons less than 19 years of age. Coverage continues through the end of the month in which the Insured Person turns age 19.

*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% per exam Deductible waived

You pay 50%

### Eyeglasses and Lenses for Children

**Pediatric Frame Collection Frames**

0% per pair Deductible waived

You pay 100%

**Non-Pediatric Frame Collection Frames**

Up to 75% of the retail value

You pay 100%

**Single Vision**

0% per pair Deductible waived

You pay 100%

**Lined Bifocal**

0% per pair Deductible waived

You pay 100%

**Lined Trifocal**

0% per pair Deductible waived

You pay 100%

**Lenticular**

0% per pair Deductible waived

You pay 100%

Limited to one pair per year

### Contact Lenses for Children

**Elective**

0% per pair Deductible waived

You pay 100%

**Therapeutic**

0% per pair Deductible waived

You pay 100%

Limited to one pair per year

**Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit
## Pediatric Dental Benefits
For Insured Persons less than 19 years of age. Coverage continues through the end of the month in which the Insured Person turns age 19.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cigna DPPO Advantage Participating Providers</th>
<th>Cigna DPPO Participating Providers** and Non–Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Maximum: Class I, II, III &amp; IV</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum: Class IV</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Calendar Year Deductible: Class II, III &amp; IV</td>
<td>Combined with Medical</td>
<td></td>
</tr>
<tr>
<td>Separate Lifetime Deductible for Class IV</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Out of Pocket Maximum: Class I, II, III &amp; IV</td>
<td>Combined with Medical</td>
<td></td>
</tr>
<tr>
<td>Class I – Preventive/Diagnostic Services</td>
<td>100%*</td>
<td>100%*</td>
</tr>
<tr>
<td>Class II – Basic Restorative Services</td>
<td>50%*</td>
<td>50%*</td>
</tr>
<tr>
<td>Class III – Major Restorative Services</td>
<td>50%*</td>
<td>50%*</td>
</tr>
<tr>
<td>Class IV – Medically Necessary Orthodontia</td>
<td>50%*</td>
<td>50%*</td>
</tr>
</tbody>
</table>

*For explanation of any additional payment responsibility to the covered person, see section entitled Dental PPO – Participating and Non-Participating Providers.

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

## INPATIENT HOSPITAL FACILITY SERVICES

### Inpatient Hospital Services

<table>
<thead>
<tr>
<th>Facility</th>
<th>In-Network benefit level for an Emergency Medical Condition (In-Network Deductible and Out of Pocket apply), otherwise 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Charges</td>
<td>15%</td>
</tr>
<tr>
<td>Professional Charges</td>
<td>15%</td>
</tr>
</tbody>
</table>

### Emergency Admissions

<table>
<thead>
<tr>
<th>Facility</th>
<th>In-Network benefit level for an Emergency Medical Condition (In-Network Deductible and Out of Pocket apply), otherwise 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Charges</td>
<td>15%</td>
</tr>
<tr>
<td>Professional Charges</td>
<td>15%</td>
</tr>
</tbody>
</table>
## OUTPATIENT SERVICES

<table>
<thead>
<tr>
<th>Service Description</th>
<th>IN NETWORK YOU PAY</th>
<th>OUT OF NETWORK YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Other Laboratory and Radiology Services (including Breast Tomosynthesis)</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>Facility and interpretation charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physician’s Office</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Free-standing/Independent lab or x-ray facility</strong></td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Outpatient Hospital lab or x-ray</strong></td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>BENEFIT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IN NETWORK</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>YOU PAY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OUT OF NETWORK</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>YOU PAY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Radiological Imaging (including MRI’s, MRA’s, CAT Scans, PET Scans)</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>Facility and interpretation charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac &amp; Pulmonary Rehab</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Short-Term Rehabilitative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, Occupational Speech Therapy</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>Maximum of 40 visits per Insured Person, per calendar year for all therapies, In- and Out-of-Network combined.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Short-Term Rehabilitative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>Maximum of 20 visits per Insured Person, per calendar year, In- and Out-of-Network combined.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Habilitative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum of 40 visits per Insured Person per calendar year, In- and Out-of-Network combined.</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Autism Services</strong></td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>OUTPATIENT SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital Facilities</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>EMERGENCY &amp; URGENT CARE SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>15%</td>
<td>In-Network benefit level for an Emergency Medical Condition (In-Network Deductible and Out of Pocket apply).</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>15%</td>
<td>In-Network benefit level for an Emergency Medical Condition (In-Network Deductible and Out of Pocket apply).</td>
</tr>
<tr>
<td>Service</td>
<td>In-Network Benefit</td>
<td>Out-of-Network Benefit</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Ambulance</td>
<td>15%</td>
<td>In-Network benefit level for an Emergency Medical Condition (In-Network Deductible and Out of Pocket deductible apply).</td>
</tr>
<tr>
<td><strong>OTHER HEALTH CARE FACILITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services at Other Health Care Facilities</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>Maximum of 90 days per Insured Person per Calendar Year combined In- and Out-of-Network for all facilities listed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100 days maximum per Insured Person, per Calendar Year, In- and out-of-network combined</td>
<td>$50 Home Health Deductible then, 15%</td>
<td>$50 Home Health Deductible then, 25%</td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>DURABLE MEDICAL EQUIPMENT (DME)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td><strong>MENTAL HEALTH &amp; SUBSTANCE USE DISORDERS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient (Includes Acute and Residential Treatment)</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>Outpatient (Includes individual, group, intensive outpatient and partial hospitalization)</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>Office Visit</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>All other outpatient services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td><strong>MATERNITY CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity (Pregnancy and Delivery)/Complications of Pregnancy</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>PRESCRIPTION DRUGS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cigna Retail Pharmacy Drug Program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Cigna will not provide coverage for more than a 30-day supply of any opioid analgesic for the initial prescription or refills for such prescriptions.</td>
<td>IN-NETWORK YOU PAY (Based on Cigna contract allowance)</td>
<td>OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)</td>
</tr>
<tr>
<td>Tier 1: Retail Preferred Generic</td>
<td>15% per Prescription or refill</td>
<td>50% per Prescription or refill</td>
</tr>
<tr>
<td>Up to a 90 day maximum supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2: Retail Non-Preferred Generic</td>
<td>15% per prescription or refill</td>
<td>50% per Prescription or refill</td>
</tr>
<tr>
<td>Up to a 90 day maximum supply</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Tier 3: Retail Preferred Brand
Up to a 90 day maximum supply  
15% per prescription or refill  
50% per Prescription or refill

### Tier 4: Retail Non-Preferred Brand
Up to a 90 day maximum supply  
50% per prescription or refill  
50% per Prescription or refill

### Tier 5: Retail Specialty (Generic and Brand Name medications that meet criteria of Specialty drugs)
Up to a 30 day maximum supply  
15% per prescription or refill  
50% per Prescription or refill

### Retail Pharmacy
Preventive Drugs regardless of Tier
Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including 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  
50% per Prescription or refill

### MAIL ORDER DRUGS
Cigna Mail Order Pharmacy Drug Program
Note: Cigna will not provide coverage for more than a 30-day supply of any opioid analgesic for the initial prescription or refills for such prescriptions.  
Maximum 90-day supply  
Maximum 30-day supply for Specialty Medications

### Tier 1: Mail Order Preferred Generic
Up to a 90 day maximum supply  
15% per Prescription or refill  
50% per prescription or refill

### Tier 2: Mail Order Non-Preferred Generic
Up to a 90 day maximum supply  
15% per prescription or refill  
50% per prescription or refill

### Tier 3: Mail Order Preferred Brand
Up to a 90 day maximum supply  
15% per prescription or refill  
50% per prescription or refill

### Tier 4: Mail Order Non-Preferred Brand
Up to a 90 day maximum supply  
50% per prescription or refill  
50% per prescription or refill

### Tier 5: Mail Order Specialty (Generic or Brand Name medications that meet criteria of Specialty Medications)
Up to a 30 day maximum supply  
15% Per prescription or refill  
50% per prescription or refill

### Mail Order Pharmacy
Preventive Drugs regardless of Tier Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including 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  
50% per prescription or refill
EXCLUSIONS AND LIMITATIONS:

- 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 for treatment of complications of non-covered procedures or services.
- Services or supplies that are not Medically Necessary or state or federally mandated.
- Services or supplies that Cigna considers to be for Experimental Procedures or Investigative Procedures, except as described under this Policy.
- 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.
- For or in connection with an Injury or Illness arising out of, or in the course of, any employment for wage or profit. Any services provided by a local, state or federal government agency, except when payment under this Policy is expressly required by federal or state law.
- 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.
- 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, except as specifically stated and provided under the benefit for “Extended Day Treatment Programs” in this Policy.
- Inpatient or outpatient services of a private duty nurse. Except as specifically stated under Home Health Care in the section of this Policy titled “Comprehensive Benefits What the Policy Pays For”.
- 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.
- **Services received during an inpatient stay** when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental health.

- **Services which are self-directed** to a free-standing or Hospital based diagnostic facility.

- **Services ordered by a Physician or other provider** who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service, or
  - Is not actively involved in your medical care after the service is received.
  - This exclusion does not apply to mammography.

- **Complementary and alternative medicine services**, including but not limited to: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; meditation; visualization; acupuncture; acupressure; reflexology; rolfing; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnosis; energy-balancing; breathing exercises; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf; and any other alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to chiropractic, naturopathic, optometric, podiatric, short term rehabilitative or habilitative services that are covered under this Policy.

- **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, except as specifically stated and provided under the benefit for “Extended Day Treatment Programs” in this Policy.

- Services performed by **unlicensed practitioners or services which do not require licensure** to perform, for example mediation, breathing exercises, guided visualization.

- 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, except as described in this Policy.

- **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 provided in this Policy, limited to the least expensive professionally adequate device. For the purposes of this exclusion, a hearing aid is any device that amplifies sound.

- **Routine hearing tests** except as specifically provided in this Policy 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**, expect as specifically stated in this Policy.

- **Private duty nursing** except when provided as part of the Home Health Care Services or Hospice Services benefit 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. 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 Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy. Cosmetic surgery and therapy does not include gender reassignment services [consistent with World Professional Association for Transgender Health (WPATH) recommendations].

- **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, except those related to covered services for Early Intervention Services, Autism Services and Services for Mental Health and Substance Use Disorder Services.

- Any services provided by or at a **place for the aged, a nursing home**, or any facility a significant portion of the activities of which include rest, recreation, leisure, or any other services that are not Covered Services.

- Services and procedures for **redundant skin surgery**, including abdominoplasty/panniculectomy, removal of skin tags, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; varicose veins; rhinoplasty, blepharoplasty and; orthognathic surgeries regardless of clinical indications.

- Any treatment, prescription drug, service or supply to treat **sexual dysfunction**, enhance sexual performance or increase sexual desire. **Reversal** of male or female voluntary Sterilization.
- **Infertility services** such as Donor charges and services; Gestational carriers and surrogate parenting arrangements; and experimental, investigational or unproven infertility procedures or therapies.

- 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, non-prescription drugs, and investigational and experimental drugs, and **Self-administered Injectable Drugs**, and **Self-administered Injectable Drugs**, except as stated in the Benefit Schedule and in the Prescription Drug Benefits section 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.

- **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).

- Fees associated with the **collection or donation of blood or blood products**, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

- Blood administration for the purpose of general improvement in physical condition.

- **Orthopedic shoes** (except when joined to braces) or shoe inserts, including orthotics except for Insured’s with the diagnosis of diabetes.

- 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 except as specifically provided in the treatment of cancer, 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, Occupational and/or Speech Therapy/Medicine** and Habilitative Services except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and under ‘Services for Short Term Rehabilitation Therapy’ or ‘Habilitative Services’ in the section of this Policy titled “Comprehensive Benefits What the Policy Pays For”.
- **Any Drugs, medications, or other substances** dispensed or administered in any outpatient setting except as specifically stated in this Policy. This includes, but is not limited to, items dispensed by a Physician.
- **Syringes**, except as stated in this Policy.
- **All Foreign Country Provider charges** are excluded under this Policy except as specifically stated under “Treatment received from Foreign Country Providers” in the section of this Policy titled “Comprehensive Benefits What the Policy Pays For”.
- **Growth Hormone Treatment** except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person’s condition. 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 for the treatment of diabetes.
- **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**.
Charges for *elective abortions*.

Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

**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.

Please call the Member Services number on the back of Your ID card or check mycigna.com, under “View Medical Benefit Details” for the most current listing of services that require Prior Authorization.

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

- Inpatient Hospital
- Skilled Nursing Facilities
- Extended Care, including Habilitative and Rehabilitative, Facilities
- Organ and Tissue Transplants
- Hospice Care Services
- Mental Health and Substance Use Services in a Residential Treatment Facility
- Preoperative Inpatient Admissions

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 FOR 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.
Please call the Member Services number on the back of Your ID card or check mycigna.com, under “View Medical Benefit Details” for the most current listing of services that require Prior Authorization.

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.

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

- Potential Cosmetic procedures
- CT, PET scans, MRI, MRA, nuclear cardiology
- Any surgeries on the above Prior Authorization list
- Partial Hospitalization
- Services at an Ambulatory Surgical Center
- Intensive Outpatient Psychiatric Treatment Programs
- Speech, Occupational and Physical Therapy
- Applied Behavioral Analysis (ABA)
- Infertility Services
- External prosthetic devices
- Durable Medical Equipment
- Home Health Services
- Home Infusion Services
- Injectable drugs
- Specialty drugs
- Major skin procedures
- Face/jaw surgery
- Back/Spine Procedures
- All anesthesia and/or facility charges that are provided for non-covered dental services
- Ear devices
- Oral Pharynx Procedures
- Orthotics and Prosthetics
- Radiation Therapy
- Sleep Therapy
- Genetic Testing/Counseling
- Therapeutic/Interventional Radiology
- Unlisted Procedures (procedures and services for which a specific CPT or HCPCS code has not been established. The procedure may be new, used infrequently or may be a variation of another procedure)
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.

Pharmacy Formulary Exception
Process/Prior Authorization

Certain Prescription Drugs also may require Prior Authorization by Cigna. Coverage for certain Prescription Drugs and Related Supplies require the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a Step Therapy determination. Step Therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. Pain Management drugs are not subject to the Step Therapy program. 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 Prior Authorization or Prescription Drug List exception will be reviewed and completed by Cigna within 72 hours of receipt. The Physician should make this request before writing the prescription.

An expedited review may be requested by the prescribing Physician when a Member is suffering from a health condition that may seriously jeopardize the Member’s life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a drug not on Cigna's Prescription Drug List. The expedited review will be reviewed and completed by Cigna within 24 hours of receipt. 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 this Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered. Please see the section of this Policy entitled “WHEN YOU HAVE A COMPLIANT OR AN APPEAL” which describes the process for the External Independent Review.

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

RENEWABILITY, ELIGIBILITY, and CONTINUATION

Reinstatement:
If this Policy cancels because You did not pay Your premium within the time granted You for payment, then We may, upon Your request and at Our discretion, agree to reinstate coverage under this Policy.

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

Any premiums accepted in connection with a reinstatement will be applied to a period for which You have not previously paid premium, but not to exceed sixty days prior to the date of reinstatement. There is a $50 fee for reinstatement.

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

Cancellation:  We may cancel this Policy only in the event of any of the following:
1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period for plans not purchased from the Marketplace.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or intentional misrepresentation of material fact in connection with this Policy or coverage subject to the Time Limit on Certain Defenses provision.
5. When We cease to offer policies of this type to all individuals in your class, In this event, Connecticut 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 Connecticut, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.

7. When all Insured Persons on this Policy no longer live within the Coverage Area of the Policy.

8. When Cigna determines that any premium payment for this Policy is being paid directly or indirectly from any source other than You, Your Family Members or an Acceptable Third Party Payor; however, if You, Your Family Members or an Acceptable Third Party Payor make all premium payments for this Policy that are due after the date of Cigna’s determination, the Policy shall remain in effect, subject to all other terms and conditions contained herein.

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

Renewal: This Policy renews on a Calendar Year basis.

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

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

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

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

- Your lawful spouse or partner to a civil union.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, Your spouse's or Your partner to a civil union's unmarried children, regardless of age, enrolled prior to age 26, who are incapable of self support due to medically certified continuing 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 61 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.

- Any other person dependent on You, including a totally disabled adult.
- Your own, Your spouse’s or Your partner to a civil union’s Newborn children are automatically covered for the first 61 days of birth. 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 61 days from the earlier of legal placement of the child for adoption or the child beginning to live with You in advance 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 61 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.

Specific Causes for Ineligibility

Except as described in the Continuation section, You and Your Family Member(s) 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 a dependent child – on the Policy anniversary date, which is equal to the Effective Date that follows the date the child turns 26.
- For You and Your Family Member(s) - when the Insured Person no longer meets the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When all Insured Persons on this Policy no longer live within the Coverage Area of the Policy.

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

Continuation

- If an Insured Person’s eligibility under this Policy would terminate due to the Insured’s death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured’s failure to pay premium, that Member has the right to continuation of his or her insurance. Coverage will be continued if the Member exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Agreement would
otherwise terminate. In such a case, coverage coverage will continue without evidence of insurability.

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

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

If You did not purchase Your plan from a 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 Insured Person 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 with 30 days' prior written notice to You. Premiums will be revised during the Renewal Period each year. 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 Policy.

Amendments: CTIND2015CHNGSAMND05/2014
               CTIND2016CHNGSAMND11/2015