Cigna Health and Life Insurance Company

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

CIGNA CONNECT 700-3 PLAN

This Major Medical Expense Coverage Exclusive Provider Plan covers In-Network Services

POLICY FORM NUMBER: MOINDEPO072016

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, copayment provisions, or other limitations which may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

Section I.

Coverage is provided by Cigna Health and Life Insurance Company (referred to herein as "Cigna"), an insurance company that provides participating provider benefits.

To **obtain additional information**, including Provider information write to the following address or call the toll-free number:

Cigna Health and Life Insurance Company
Individual Services Missouri
P.O. Box 30365
Tampa FL 33630-3365
1-877-484-5967

An **Exclusive Provider Plan** enables the Insured to incur lower medical costs by using providers in the Cigna network.

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

A **Non-Participating Provider** (Out-of-Network Provider) is a Provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered.

Section II.

Covered Services and Benefits

Deductibles:

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

Family Deductible applies if You have a family plan and You and one or more of Your Family Member(s) are Insured under this Policy. Each Insured Person can contribute up to the Individual Deductible amount toward the Family Deductible. The Individual Deductible paid by each Family Member counts towards satisfying the Family Deductible. Once the Family Deductible amount is satisfied, the remaining Individual Deductibles will be waived for the remainder of the Year. The amount of the Family Deductible is described in the Schedule of Benefits section of this Policy.

Out-of-Pocket Maximums:

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

Family Out-of-Pocket Maximum is an accumulation of Covered Expenses that applies if You have a family plan and You and one or more of Your Family Member(s) are insured under this Policy. The Individual Out-of-Pocket paid by each Family Member counts toward satisfying the Family Out-of-Pocket Maximum. Each Insured Person can contribute up to the Individual Out-of-Pocket amount toward the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum has been met for the Year You and Your Family Member(s) will no longer be responsible to pay Coinsurance for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Family Out-of-Pocket Maximum and will always be paid by You. The amount of the Family Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

BENEFIT SCHEDULE

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

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

Remember, services from 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.

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.	IN-NETWORK PROVIDER – YOU PAY (Based on the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY YOU PAY:
Medical Benefits	
Annual Plan Deductible Individual Family	 $700 $1,400
Out-of-Pocket Maximum Individual Family	 $2,250 $4,500 The following do not accumulate to the Out-of-Pocket Maximum: Penalties and Policy Maximums.
Co-insurance	You and Your Family Members pay 10% of Charges after the Annual Plan Deductible

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.	IN-NETWORK PROVIDER – YOU PAY (Based on the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY 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 above for more detailed information. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of your ID card or at www.mycigna.com under "View Medical Benefit Details".	**Your In-Network Provider must obtain approval** for inpatient admissions; **or Your provider may be assessed a penalty** for non-compliance. **Your In-Network Provider must obtain approval** for selected outpatient procedures and services; **or Your provider may be assessed a penalty** for non-compliance.
All Preventive Well Care Services Please refer to "Comprehensive Benefits: What the Policy Pays For" section of this Policy for additional details	0%, Deductible waived
Pediatric Vision Care Performed by an Ophthalmologist or Optometrist for Insured Persons less than 19 years of age. **Please be aware that the Pediatric Vision network is different from the network for Your medical benefits** **Comprehensive Eye Exam and Refraction for Children** Limited to one exam per year **Eyeglasses and Lenses for Children** Single Vision, Lined Bifocal, Lined Trifocal, Lenticular, and Frames Limited to one pair per year **Contact Lenses for Children** Elective and Therapeutic Limited to one pair per year **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	0% per exam, Deductible waived 0% per pair, Deductible waived 0% per pair, Deductible waived

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.	IN-NETWORK PROVIDER – YOU PAY (Based on the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY YOU PAY:
Physician Services	
Office Visit / Home Visit	
Primary Care Physician (PCP)	$10 Copayment per office visit, Deductible waived
Specialist, (including consultant, referral and second opinion services) (PCP Referral and/or Plan Authorization is NOT required)	$45 Copayment per office visit, Deductible waived
Note: if a Copayment applies for OB/GYN visits: If Your doctor is listed as a PCP in the provider directory, You or Your Family Member will pay a PCP Copayment. If Your doctor is listed as a specialist, You or Your Family Member will pay the specialist Copayment.	
Surgery in Physician's office	10%
Outpatient Professional Fees for Surgery (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy)	10%
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	10%
In-hospital visits	10%
Allergy testing and treatment/injections	10%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.	IN-NETWORK PROVIDER – YOU PAY (Based on the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY YOU PAY:
Hospital Services	
Inpatient Hospital Services	
Facility Charges	10%
Professional Charges	10%
Emergency Admissions	Benefits are shown in the Emergency Services Schedule
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	10%
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation charges	10%
All Other Laboratory and Radiology Services Facility and interpretation charges	
Physician's Office	10%
Free-standing lab or x-ray facility	10%
Outpatient hospital lab or x-ray	10%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.	IN-NETWORK PROVIDER – YOU PAY (Based on the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY YOU PAY:
Short-Term Rehabilitative Services Physical/Manipulation (excluding Chiropractic) Therapy Maximum of 20 visits per Insured Person, per calendar year **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders.	$10 Copayment per visit, Deductible waived
Short-Term Rehabilitative Services Occupational Therapy Maximum of 20 visits per Insured Person, per calendar year **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders.	$10 Copayment per visit, Deductible waived
Short-Term Rehabilitative Services Speech Therapy Unlimited visits per Insured Person, per calendar year	10%
Chiropractic Services Maximum of 26 visits per Insured Person, per calendar year. Limits based on Medical Necessity guidelines. **Note**: Additional visits may be authorized based on Medical Necessity.	10%
Cardiac Rehabilitation Maximum of 36 visits per Insured Person, per calendar year. Limits based on Medical Necessity guidelines.	10%
Pulmonary Rehabilitation Maximum of 20 visits per Insured Person, per calendar year. Limits based on Medical Necessity guidelines.	10%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.	IN-NETWORK PROVIDER – YOU PAY (Based on the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY YOU PAY:
Habilitative Services **Physical/Manipulation (excluding Chiropractic) Therapy** Maximum of 20 visits per Insured Person, per calendar year **Note**: Maximums for Short-term Rehabilitative services do not apply to Habilitative services. Maximums for Habilitative Services do not apply to services for the treatment of Autism Spectrum Disorders.	$10 Copayment per visit, Deductible waived
Habilitative Services **Occupational Therapy** Maximum of 20 visits per Insured Person, per calendar year **Note**: Maximums for Short-term Rehabilitative services do not apply to Habilitative services. Maximums for Habilitative Services do not apply to services for the treatment of Autism Spectrum Disorders.	$10 Copayment per visit, Deductible waived
Habilitative Services **Speech Therapy** Unlimited visits per Insured Person, per calendar year	10%
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	Copay or Coinsurance applies for specific benefit provided
Women's Contraceptive Services, Family Planning and Sterilization	0%, Deductible waived

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.	IN-NETWORK PROVIDER – YOU PAY (Based on the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY YOU PAY:
Male Sterilization	Copay or Coinsurance applies for specific benefit provided
Maternity (Pregnancy and Delivery)/Complications of Pregnancy	
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)	10%
Hospital Delivery charges	10%
Prenatal testing or treatment billed separately from "global" fee	10%
Postnatal visit or treatment billed separately from "global" fee	PCP or Specialist Office Visit benefit applies
Autism Spectrum Disorders	
Diagnosis of Autism Spectrum Disorder	
Office Visit	PCP or Specialist Office Visit benefit applies
Diagnostic testing	10%
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

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.	IN-NETWORK PROVIDER – YOU PAY (Based on the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY YOU PAY:
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 150 days per Insured Person per calendar year	10%
Home Health Services Maximum of 100 visits per Insured Person, per calendar year.	10%
Private Duty Nursing Maximum of 82 visits per Insured Person per calendar year; Maximum of 164 visits per Insured Person per lifetime	10%
Durable Medical Equipment	10%
Prosthetics	10%
Hospice	
Inpatient	Inpatient Hospital Services benefit applies
Outpatient	10%
Dialysis	
Inpatient	Inpatient Hospital Services benefit applies
Outpatient	10%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.	IN-NETWORK PROVIDER – YOU PAY (Based on the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY YOU PAY:
Mental, Emotional or Functional Nervous Disorders	
Inpatient (Includes acute and residential treatment)	Inpatient Hospital Services benefit applies
Outpatient (Includes individual, group, intensive outpatient and partial hospitalization and two Non-Participating Provider office visits.)	
Office Visit	$45 Copayment per visit, Deductible waived
All other Outpatient services	10%
Substance Use Disorder	
Inpatient Rehabilitation (Includes acute and residential treatment)	Inpatient Hospital Services benefit applies
Outpatient (Includes individual, group, intensive outpatient and partial hospitalization)	
Office Visit	$45 Copayment per visit, Deductible waived
All other Outpatient services	10%
Smoking Cessation **Medical treatment** Maximum of 2 courses of treatment per Year (Prescription Drugs for smoking cessation treatment are covered under the Prescription Drug benefit)	0%, Deductible waived

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.	IN-NETWORK PROVIDER – YOU PAY (Based on the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY 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** **Travel Benefit,** (Only available through Cigna Lifesource Transplant Network ® Facility) Travel benefit maximum payment of $10,000 per transplant **Other Cigna Network Facility**	0% 10%
Infusion and Injectable Specialty Prescription Medications and related services or supplies administered by a medical professional in an office or outpatient facility	10%
Dental Care (other than Pediatric) Limited to treatment for accidental injury to natural teeth within six months of the accidental injury	10%

BENEFIT INFORMATION	IN-NETWORK (PARTICIPATING PROVIDERS) – YOU PAY (Based on Cigna Negotiated Rate)	OUT-OF-NETWORK (NON-PARTICIPATING PROVIDERS – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Emergency Services Benefits		
NOTE: This Plan covers Emergency Services from In and Out-of-Network Providers as shown:		
Emergency Services		
Hospital Emergency Room	10%	In-Network benefit level for an Emergency Medical Condition, otherwise Not Covered
Urgent Care Services	$50 Copayment per visit, Deductible waived	In-Network benefit level for an Emergency Medical Condition, otherwise Not Covered
Ambulance Services Note: coverage for Medically Necessary transport to the nearest facility capable of handling an Emergency Medical Condition.		
Emergency Transport	10% for Ground, Air or Water transport	In-Network benefit level for an Emergency Medical Condition, otherwise Not Covered for Ground or Air transport
Non-Emergency Transport	Not Covered	Not Covered

BENEFIT INFORMATION	IN-NETWORK (PARTICIPATING PROVIDERS) – YOU PAY (Based on Cigna Negotiated Rate)	OUT-OF-NETWORK (NON-PARTICIPATING PROVIDERS – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Inpatient Hospital Services (for emergency admission to an acute care Hospital)		
Hospital Facility Charges Emergency Services from an Out-of-Network Provider are covered at the In-Network benefit level until the patient is transferrable to an In-Network facility. Out-of-Network facility benefits are not covered once the patient can be transferred, whether or not the transfer takes place.	10%	In-Network benefit level until transferable to an In-Network Hospital, if not transferred then Not Covered
Professional Services	10%	In-Network benefit level until transferable to an In-Network Hospital, if not transferred then Not Covered

BENEFIT INFORMATION	RETAIL PHARMACY	CIGNA HOME DELIVERY PHARMACY
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
In the event that You request a Brand-Name drug that has a Generic equivalent, You will be financially responsible for the amount by which the cost of the Brand-Name drug exceeds the cost of the Generic drug, plus the Generic Copay or Coinsurance shown in the Benefit Schedule.		
Prescription Drug Deductible	**Integrated Medical and Prescription Drug Deductible**	
	Cigna Retail Pharmacy Drug Program **YOU PAY PER PRESCRIPTION OR REFILL:**	**Cigna Mail Order Pharmacy Drug Program** **YOU PAY PER PRESCRIPTION OR REFILL:**
Tier 1: Preferred Generic	$5 Copayment, Deductible waived per prescription or refill Up to a 90-day maximum supply. You pay a Copayment for each 30-day supply.	$12 Copayment, Deductible waived per Prescription or refill 90-day maximum supply.
Tier 2: Non-Preferred Generic	$12 Copayment, Deductible waived per prescription or refill Up to a 90-day maximum supply. You pay a Copayment for each 30-day supply.	$30 Copayment, Deductible waived per Prescription or refill 90-day maximum supply.
Tier 3: Preferred Brand	$40 Copayment, Deductible waived per prescription or refill Up to a 90-day maximum supply. You pay a Copayment for each 30-day supply.	$100 Copayment, Deductible waived per Prescription or refill 90-day maximum supply.
Tier 4: Retail Non-Preferred Brand	50% per prescription or refill Up to a 90-day maximum supply.	50% per Prescription or refill 90-day maximum supply.

BENEFIT INFORMATION	RETAIL PHARMACY	CIGNA HOME DELIVERY PHARMACY
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Tier 5: Retail Specialty Generic and Brand Name medications that meet the criteria of specialty drugs	30% per prescription or refill, Deductible waived Up to a 30-day maximum.	20% per Prescription or refill, Deductible waived 30-day maximum.
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	0%, Deductible waived per prescription or refill Up to a 90-day maximum supply.	0%, Deductible waived per Prescription or refill 90-day maximum supply.

Section III.

Emergency Services and Benefits

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

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

Emergency Services means:

- a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider; and/or
- means, with respect to an Emergency Medical Condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Section IV.

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 V.

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, Copayments, Coinsurance 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 and two sessions per year for the purpose of diagnosis or assessment of mental health, are excluded from coverage under this Policy and are the responsibility of the Insured.

Limited Benefits

If you submit a claim for services which have a maximum limit we will only apply the allowed per day or per event amount (whichever applies) toward your Deductibles, or Out-Of-Pocket Maximums.

Section VI.

Exclusions, Limitations, and Reductions

A. The Exclusive 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) and two sessions per year for the purpose of diagnosis and assessment of mental health.
- 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; except for services for Emergency Medical Conditions or services resulting from complications related to an approved Clinical Trial.
- Services or supplies that are **not Medically Necessary**.
- Services or supplies that are considered to be for **Experimental Procedures or Investigative Procedures**.
- 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.
- 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 undeclared)**; (b) the **inadvertent release of nuclear energy** when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person **participating in the military service of any country**; (d) an Insured Person **participating in an insurrection, rebellion, or riot;** (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a **felony** (whether or not charged) **or as a direct result of the Insured Person being engaged in an illegal occupation;** (f) an Insured Person being intoxicated, as defined by applicable state law in the state where the illness occurred or under the influence of illegal narcotics or non-prescribed controlled substances unless administered or prescribed by Physician.
- Any **services provided by a local, state or federal government agency**, except when payment under this Policy is expressly required by federal or state law.
- Any **services required by state or federal law** to be supplied by a public school system or school district.
- Any **services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.

- **If the Insured Person is eligible for Medicare** Part A, B or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
- **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Professional **services or supplies received or purchased directly or on Your behalf by anyone, including a Physician, from** any of the following:
  - Yourself or Your employer;
  - a person who lives in the Insured Person's home, or that person's employer;
  - a person who is related to the Insured Person by blood, marriage or adoption, or that person's employer.
- **Custodial Care**.
- **Private duty nursing**, when provided as part of the under Home Health Care Services or Hospice Services benefit in this Policy.
- 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.
- 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. Services specifically listed as covered under "Short Term Rehabilitative Therapy" and "Habilitative Therapy" are not subject to this exclusion.
- Any services or supplies 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.
- **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.
- 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.

- 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.
- **Dental services**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **Dental Implants**: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
- **Hearing aids** including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as provided under Preventive Care for hearing aids for initial amplification, limited to the least expensive professionally adequate device. For the purposes of this exclusion, a hearing aid is any device that amplifies sound. This Exclusion does not apply to cochlear implants.
- **Routine hearing tests** except as provided under Preventive Care which include necessary rescreening, audiological assessment and follow-up, and initial amplification. The screening will include the use of at least one of the following physiological technologies: automated or diagnostic brainstem response (ABR); otacoustic emissions (OAE); or other technologies approved by the Missouri Department of Health.
- **Genetic screening** or pre-implantations genetic screening: general population-based genetic screening 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).
- **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, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.

- **Aids or devices that assist with nonverbal communication**, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- **Non-Medical counseling or ancillary services**, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, 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 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 surgeries; surgical treatment of varicose veins; rhinoplasty, blepharoplasty, and orthognathic surgeries **regardless of clinical indications**.
- Procedures, surgery or treatments **to change characteristics of the body to those of the opposite sex** including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery. This also includes any medical, surgical or psychiatric treatment or study related to sex change.
- Any treatment, prescription drug, service or supply to treat **sexual dysfunction**, enhance sexual performance or increase sexual desire.
- 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 elective sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT).
- **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- 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, except for Insulin;
- **All noninjectable Prescription Drugs, injectable Prescription Drugs that do not require Physician supervision** and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, and **Self-administered Injectable Drugs,** except as provided in the Prescription Drug benefits of this Policy.
- **Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision,** except as otherwise stated in this Policy. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- Fees associated with the **collection or donation of blood or blood products**, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

- Blood administration **for the purpose of general improvement in physical condition.**
- **Orthopedic shoes** (except when joined to braces or as required by law for diabetic patients), shoe inserts, foot orthotic devices.
- 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, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and under 'Physical and/or Occupational Therapy/Medicine' in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- All **Foreign Country Provider charges** are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".

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

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

- Drugs not approved by the Food and Drug Administration;
- Any drugs that are not on the Prescription Drug List and not otherwise approved as Medically Necessary;
- Drugs available over the counter that do not require a prescription by federal or state law except as otherwise stated in this Policy, or specifically required under the Patient Protection and Affordable Care Act (PPACA);
- Drugs that do not require a Federal legend (a Federal designation for drugs requiring supervision of a Physician), other than insulin;
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- 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;
- Infertility related drugs, except those required by the Patient Protection and Affordable Care Act (PPACA);
- Any drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido/ and or sexual desire;

- Any drugs used for weight loss, weight management, metabolic syndrome, and antiobesity agents;
- Any drugs that are Experimental or Investigational as described under the Medical "Exclusions" section of the Policy; except as specifically stated in the sections of this Policy titled “Clinical Trials”, “Clinical Trial Costs” and “Off Label Drugs”;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals;
- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies; except for those pertaining to Diabetic Supplies and Equipment;
- Implantable contraceptive products inserted by the Physician are covered under the Plan’s medical benefits;
- Prescription vitamins (other than prenatal vitamins), herbal supplements and dietary 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 Plan;
- 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 therapy for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Drugs obtained outside the United States;
- Any fill or refill of Prescription Drugs and Related Supplies to replace those lost, stolen, spilled, spoiled or damaged before the next refill date;
- 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;
- Drug convenience kits;

- Prescriptions more than one year from the original date of issue;
- Any costs related to the mailing, sending or delivery of Prescription Drugs;
- Any intentional misuse of this benefit, including prescriptions purchased for consumption by someone other than the Insured Person.

C. The Exclusive 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 and Non-Preferred Brand and up to a 30-day supply of Specialty medications, unless limited by the drug manufacturer's packaging: or
- Up to a 90-day supply at a mail-order Pharmacy for Preferred Generic, Non-Preferred Generic, Preferred Brand and Non-Preferred Brand and up to a 30-day supply of Specialty medications, unless limited by the drug manufacturer's packaging; or
- Tobacco cessation medications that are included on Cigna's Prescription Drug List are limited to two 90-day supplies per Year.
- Managed drug limits (MDL) may apply to dose and/or number of days' supply of certain drugs; managed drug limits are based on recommendations of the federal Food and Drug Administration (FDA) and the drug manufacturer.
- To a dosage and/or dispensing limit as determined by the P&T Committee.
- Infusion and Injectable Specialty Prescription Medications may require Prior Authorization.
- If a prescription drug covered by the Plan is prescribed in a single dosage amount for which the particular prescription drug is not manufactured in such single dosage amount and requires dispensing the particular prescription drug in a combination of different manufactured dosage amounts, Cigna will only impose one Copay for the dispensing of the combination of manufactured dosages that equal the prescribed dosage for the prescription drug. The Copay requirement will not apply to prescriptions in excess of a 30 day supply. Cigna provides reimbursement forms for the additional Copay if the override is not in place prior to filling the prescription.

Drug claim forms for are available upon written request to:

Cigna Pharmacy Service Center
P.O. Box 188053
Chattanooga TN 37422-8053

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

D. The Exclusive 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 Exclusive Provider Plan limits Pediatric Vision Benefits for:

No payment will be made for expenses incurred for:

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

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

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

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 the penalty amount.

Penalties will apply under the following circumstances:

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

To verify Prior Authorization requirements for inpatient and outpatient 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”

Section VIII.

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 Your Provider by calling the number on the back of Your ID card. Prior Authorizations are performed through a utilization review program by a Review Organization with which Cigna has contracted.

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 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 Your Provider by calling the number on the back of Your ID card. Outpatient Certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should only be requested for nonemergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

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

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

PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. Prior Authorization does not guarantee payment of benefits. Coverage is always subject to other requirements of this Policy 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. For retrospective review determinations, Cigna shall make the determination within thirty working days of receiving all necessary information. Cigna shall provide notice in writing of Cigna's determination to a covered person within ten working days of making the determination.

Prior Authorization—Prescription Drugs

Prior Authorization or Step Therapy is required for certain Prescription Drugs and Related Supplies. Coverage for certain Prescription Drugs and Related Supplies requires You or Your 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 You or Your Physician believes Prescription Drugs or Related Supplies not on Cigna's Drug List 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 a Prescription Drug or Related Supply that is on Cigna's Prescription Drug List or in a Step Therapy Protocol, and the Prescription Drug or Related Supply has been detrimental to the Insured Person's health or has been ineffective in treating the condition and, in the opinion of the prescribing Physician, is likely to again be detrimental to the Insured Person's health or ineffective in treating the condition. 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 an Insured Person is suffering from a health condition that may seriously jeopardize the Insured Person's life, health, or ability to regain maximum function or when an Insured Person 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 Cigna's pharmacy 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, and writes the prescription, 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 specific Prescription Drug List exceptions or a Prior Authorization request, call Customer Service at the toll-free number on the back of Your ID card.

Section IX.

Complaint Resolution Procedures

WHEN YOU HAVE A COMPLAINT OR GRIEVANCE

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

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

Start with Customer Service

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

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

If you are not satisfied with the results of a coverage decision, you can start the grievance procedure.

Grievance Procedure

Cigna has a grievance procedure for resolving disputes regarding (a) availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (b) claims payment, handling or reimbursement for health care services; or (c) matters pertaining to the contractual relationship between an covered person and a health carrier.

To initiate a grievance, you must submit a request for a grievance in writing, no more than one year from the date of receipt of a denial notice, to the following address:

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

You should state the reason why you feel your grievance should be approved and include any information supporting your grievance. If you are unable or choose not to write, you may ask to register your grievance by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form. We will acknowledge the receipt of your grievance within ten working days.

Grievances will be reviewed by a Committee consisting of individuals, with the following qualifications: (a) Other covered persons, b) Representatives of Cigna that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance, c) Where the grievance involves an adverse determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance. Others who have a "need to know" may attend the Committee Meetings. The Participant and/or his/her representative may participate via conference call. A Same or Similar Specialist opinion must be obtained for standard Medical Necessity grievances. This Same or Similar Specialist opinion is considered in the Committee decision. A Physician Reviewer must be responsible for all denial decisions by Committee. Notice of the committee meeting will be made within 10 calendar days in advance of the scheduled date of the meeting.

We will respond in writing with a decision within the lesser of 20 business days or 30 calendar days after we receive a grievance. If more time or information is needed to make the determination, we will notify you in writing on or before the 20th business day after receipt of the grievance to request an extension of up to 30 business days and to specify any additional information needed to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the grievance, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

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

You may request that the grievance process be expedited if (a) the 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 you severe pain which cannot be managed without the requested services; or (b) your grievance involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your grievance 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 grievance would be detrimental to your medical condition.

When a grievance is expedited, we will respond orally with a decision within 72 hours, followed up in writing within 3 calendar days of providing notification of the determination.

Independent Review Procedure
If you are not fully satisfied with the decision of Cigna's review regarding your Medical Necessity grievance regarding a difference of opinion between a treating health care professional and Cigna concerning the medical necessity, appropriateness, health care setting, level of care, or effectiveness of a health care service, you or your representative has the option to submit the dispute to the Missouri Department of Insurance, Financial Institutions and Professional Registration for resolution (which is binding upon Cigna and the plan) by an independent external reviewer. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to request a grievance to an Independent Review Organization will not affect the claimant's rights to any other benefits under the plan.

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

To request a review, you must notify the Missouri Department of Insurance, Financial Institutions and Professional Registration following receipt of Cigna's denial. The Missouri Department of Insurance, Financial Institutions and Professional Registration may select an Independent Review Organization to review your issue.

The Independent Review Organization will render an opinion within 20 days. When requested and if (a) a delay would be detrimental to your condition, as determined by Cigna's Physician reviewer, or if (b) your grievance concerns admission, availability of care, continued stay, or health care item or service for which you received emergency services but you have not yet been discharged from a facility, the review shall be completed within three days.

Filing a Grievance with the State of Missouri
You have the right to contact the Missouri Department of Insurance, Financial Institutions and Professional Registration for assistance at any time. The Missouri Department of Insurance, Financial Institutions and Professional Registration may be contacted at the following address and telephone number:

Missouri Department of Insurance, Financial Institutions and Professional Registration
301 West High Street
P.O. Box 690
Jefferson City, MO 65102
Toll-Free Number: 1-800-726-7390

Notice of Benefit Determination on Grievance
Every notice of a determination on grievance will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; 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; a statement describing any voluntary grievance procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); 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 grievance, 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 information about any office of health insurance consumer assistance or ombudsman available to assist you in the grievance process. A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information
Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; 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; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan 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.

Legal Action
If your plan is governed by ERISA, you have the right to bring a civil action in Federal Court under Section 502(a) of ERISA if you are not satisfied with the outcome of the Grievances Procedure.

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.

Renewability, Eligibility, and Continuation

1. The Policy will renew except for the specific events stated in the Policy. Cigna may change the premiums of the Policy with 30 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. We will only change premiums on an Annual basis.

2. The Individual Plan is designed for residents of Missouri 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 Member(s) will become ineligible for coverage:

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

4. If an Insured Person's eligibility under this Plan 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, the Insured Person's insurance will be continued, under the same plan they are currently insured under, if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. In the event of divorce, the Insured Spouse may continue coverage if the application is made and the appropriate monthly premium is paid within 60 days following entry of a valid divorce decree. Coverage will continue without evidence of insurability. Any probationary or waiting periods are considered as being met to the extent coverage was in force under the prior Plan. In the event of the Insured's death, the Insured Spouse may exercise any rights previously vested in the insured.

Section XII.

Premium

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 with 30 days' 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, 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.

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. an independent 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.