Cigna Health and Life Insurance Company may change the premiums of this Policy after 60 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You. We will only change premiums on an Annual basis.

Cigna Health and Life Insurance Company ("Cigna")
Cigna Access 6000

If You Wish To Cancel Or If You Have Questions

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

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

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

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

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

Guaranteed Renewable

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

Signed for Cigna by:

Matthew G. Manders, President

IMPORTANT NOTICES

Direct Access to Obstetricians and Gynecologists

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

Selection of a Primary Care Provider

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

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

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Introduction

About This Policy

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

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

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

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

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

IF, WITHIN 2 YEARS AFTER THE EFFECTIVE DATE OF YOUR PARTICIPATION IN THE POLICY, WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED OMITTED OR THAT YOU OR YOUR FAMILY MEMBER (S) KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND THIS COVERAGE AS OF THE ORIGINAL EFFECTIVE DATE. ADDITIONALLY, IF WITHIN 2 YEARS AFTER ADDING ADDITIONAL FAMILY MEMBER(S) (EXCLUDING NEWBORN CHILDREN OF THE INSURED ADDED WITHIN 31 DAYS AFTER BIRTH), WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED OMITTED OR THAT YOU OR YOUR FAMILY MEMBER (S) KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND COVERAGE FOR THE ADDITIONAL FAMILY MEMBER (S) AS OF THE DATE HE OR SHE ORIGINALLY BECAME EFFECTIVE. IF WE RESCIND YOUR COVERAGE, WE WILL PROVIDE YOU WITH 30 DAYS ADVANCE NOTICE AND WE WILL REFUND ALL PREMIUMS YOU PAID FOR YOUR POLICY LESS THE AMOUNT OF ANY CLAIMS PAID BY CIGNA. RESCISSION OF YOUR COVERAGE WILL RESULT IN DENIAL OF ALL PENDING CLAIMS AND, IF CLAIM PAYMENTS EXCEEDS TOTAL PREMIUM PAID, THEN CLAIMS PREVIOUSLY PAID BY CIGNA WILL BE RETROACTIVELY DENIED, OBLIGATING YOU TO PAY THE PROVIDER IN FULL FOR SERVICES RENDERED AT THE PROVIDER'S REGULAR BILLED RATE, NOT AT THE CIGNA NEGOTIATED RATE.

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

Note Regarding Health Savings Accounts (HSAs) Cigna offers some plans that are intended to qualify as "high deductible health plans" (as defined in 26 U.S.C. § 223(c)(2)). Plans that qualify as high deductible health plans may allow You, if You are an "eligible individual" (as defined in 26 U.S.C. § 223(c)(1)), to take advantage of the income tax benefits available when You establish an HSA and use the money You deposit into the HSA to pay for qualified medical expenses as allowed under federal tax law.

Cigna does not provide tax advice. **It is Your responsibility to consult with Your tax advisor or attorney about whether a plan qualifies as a high deductible health plan and whether You are eligible to take advantage of HSA tax benefits.**

IMPORTANT INFORMATION REGARDING BENEFITS

PRIOR AUTHORIZATION PROGRAM

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

PRIOR AUTHORIZATION FOR INPATIENT SERVICES

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

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

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

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

Please note that emergency admissions will be reviewed post admission.

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

PRIOR AUTHORIZATION 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. Outpatient Prior Authorization should only be requested for non-emergency procedures or services, at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

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

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

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

Retrospective Review

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

PRESCRIPTION DRUG LIST EXCEPTION and PRIOR AUTHORIZATION PROCESS

Prior Authorization or Step Therapy is required for certain Prescription Drugs and Related Supplies. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a Step Therapy determination. Step Therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If Your Physician believes 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 Member 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 Member’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 Member’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 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 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 Member Services at the toll-free number on the back of Your ID card.

BENEFIT SCHEDULE

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, Your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **READ THE ENTIRE POLICY CAREFULLY!**

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

BENEFIT INFORMATION **NOTE:** Covered Services are subject to applicable Annual Deductible, unless specifically waived.	**IN-NETWORK** **(Based on Negotiated Rate)**	**OUT-OF-NETWORK** **(Based on Maximum Reimbursable Charge)**
	COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	
MEDICAL BENEFITS		
Annual Plan Deductible	**In-Network Deductible**	**Out-of-Network Deductible**
Individual	$6, 000	$12,500
Family	$12,000	$25,000
Coinsurance	You pay 40% after deductible	You pay 50% after deductible
Out-of-Pocket Maximum	**You pay: In-Network Out-of-Pocket Maximum**	**You pay: Out-of-Network Out-of-Pocket Maximum**
Individual	$7,150	$Unlimited
Family	$14,300	$Unlimited
	The following do not accumulate to the In-Network Out-of-Pocket Maximum: Penalties and Policy Maximums.	The following do not accumulate to the Out-of-Network Out-of-Pocket Maximum: Penalties and Policy Maximums.

BENEFIT INFORMATION NOTE: Covered Services are subject to applicable Annual Deductible, unless specifically waived.	IN-NETWORK (Based on Negotiated Rate) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY
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 Provider must obtain approval** for inpatient admission; **or Your Provider may be assessed a penalty** for non-compliance. **Your Provider must be approval** for selected outpatient procedures and services; **or Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for inpatient admission; **or You may be assessed a $500 penalty** for non-compliance. **You and Your Family Member(s) must obtain approval** for selected outpatient procedures and services **or You may be assessed a $60 penalty** for non-compliance.
All Preventive Well Care Services Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details.	You pay 0%, deductible waived	You pay 50% after deductible
Pediatric Vision Services Performed by an Ophthalmologist or Optometrist For Insured Person, through the end of the month in which the enrollee turns 19 years of age. **Please be aware that the Pediatric Vision network is different from the network of your medical benefits.**		
Comprehensive Eye Exam and Refraction for Children *Limited to one exam per year*	You pay 0%, deductible waived	You pay 70%, deductible waived
Eyeglasses and Lenses for Children Single Vision, Lined Bifocal, Lined Trifocal or Standard Progressive, Lenticular Lenses and Frames *Limited to one pair per year*	You pay 0% per pair, deductible waived	You pay 70%, deductible waived

BENEFIT INFORMATION NOTE: Covered Services are subject to applicable Annual Deductible, unless specifically waived.	IN-NETWORK (Based on Negotiated Rate) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Contact Lenses for Children Elective and Therapeutic *Limited to one pair or a single purchase of a supply in lieu of Frame and Lenses, per year.* **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit.	You pay 0% per pair, deductible waived	You pay 70%, deductible waived
Physician Services **Primary Care Physician (PCP)** **Office Visit** Including allergy testing and treatment/injections, antigen administration desensitization/treatment, lab and x-ray tests and surgery done in the office	You pay 40% after deductible	You pay 50% after deductible
Specialist Including consultant, referral and second opinion services **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.	You pay 40% after deductible	You pay 50% after deductible

BENEFIT INFORMATION NOTE: Covered Services are subject to applicable Annual Deductible, unless specifically waived.	IN-NETWORK (Based on Negotiated Rate) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Physician Services, continued		
Surgery in Physician's office	You pay 40% after deductible	You pay 50% after deductible
Outpatient Professional Fees for Surgery (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy)	You pay 40% after deductible	You pay 50% after deductible
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	You pay 40% after deductible	You pay 50% after deductible
In-hospital visits	You pay 40% after deductible	You pay 50% after deductible
Expanded Access Telehealth Service Electronic visit with an Expanded Access Telehealth Physician Note: if an Expanded Access Telehealth Physician issues a Prescription, that Prescription is subject to all Plan Prescription Drug benefits, limitations and exclusions.	You pay 40% after deductible	Not Covered
Hospital Services		
Inpatient Hospital Services Facility Charges	You pay 40% after deductible	You pay 50% after deductible
Professional Charges	You pay 40% after deductible	You pay 50% after deductible

BENEFIT INFORMATION NOTE: Covered Services are subject to applicable Annual Deductible, unless specifically waived.	IN-NETWORK (Based on Negotiated Rate) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Emergency Admissions Facility Charges	You pay 40% after deductible	You pay 40% after deductible
Professional Charges	You pay 40% after deductible	You pay 40% after deductible
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities.	You pay 40% after deductible	You pay 50% after deductible
Emergency Services Emergency Room Includes a screening examination to determine whether an emergency exists and care up and through stabilization for an emergency situation.	You pay 40% after deductible	You pay the same level as in-network
Non-Emergency Services Non-Emergency Care in an emergency room	You pay 40% after deductible	You pay 50% after deductible
Ambulance Emergency transportation to the nearest facility capable of handling the emergency only.	You pay 40% after deductible	You pay the same level as in-network
Ambulance Non-Emergency transportation to the nearest facility only.	You pay 40% after deductible	You pay 50% after deductible
Urgent Care **Emergency Services**	You pay 40% after deductible	You pay the same level as in-network
Non-Emergency Services	You pay 40% after deductible	You pay 50% after deductible

BENEFIT INFORMATION NOTE: Covered Services are subject to applicable Annual Deductible, unless specifically waived.	IN-NETWORK (Based on Negotiated Rate) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Advanced Radiological Imaging Including MRIs, MRAs, CAT Scans, PET Scans, ECT, BEAM (Brain Electrical Activity), Facility and interpretation charges.	You pay 40% after deductible	You pay 50% after deductible
All Other Laboratory and Radiology Services Facility and interpretation charges		
Physician's Office	You pay 40% after deductible	You pay 50% after deductible
Free-standing /Independent lab or x-ray facility	You pay 40% after deductible	You pay 50% after deductible
Outpatient hospital lab or x-ray	You pay 40% after deductible	You pay 50% after deductible
Short-Term Rehabilitative Services **Physical, Occupational, and Speech Therapy** Maximum 60 visits per Insured Person, per calendar year for Physical, Occupational, Speech Therapy, Cardiac & Pulmonary Rehabilitation, In- and Out-of-Network combined. Maximum does not apply to services for treatment of Autism Spectrum Disorders	You pay 40% after deductible	You pay 50% after deductible
Cardiac & Pulmonary Rehabilitation Maximum 60 visits per Insured Person, per calendar year for Physical, Occupational, Speech Therapy, Cardiac & Pulmonary Rehabilitation, In- and Out-of-Network combined.	You pay 40% after deductible	You pay 50% after deductible
Spinal Manipulation Therapy Unlimited visits	You pay 40% after deductible	You pay 50% after deductible

BENEFIT INFORMATION NOTE: Covered Services are subject to applicable Annual Deductible, unless specifically waived.	IN-NETWORK (Based on Negotiated Rate) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	You pay 40% after deductible	You pay 50% after deductible
Habilitative Services Maximum 60 visits per Insured Person, per calendar year for Physical, Occupational, Speech Therapy, Cardiac & Pulmonary Rehabilitation, In- and Out-of-Network combined. Maximum does not apply to services for treatment of Autism Spectrum Disorders.	You pay 40% after deductible	You pay 50% after deductible
Womens' Contraceptive Services, Family Planning and Sterilization	You pay 0%, deductible waived	You pay 50% after deductible
Male Sterilization	You pay 40% after deductible	You pay 50% after deductible
Maternity (Pregnancy and Delivery) /Complications of Pregnancy Initial Office Visit to confirm pregnancy and subsequent prenatal visits billed separately from the "global" fee Prenatal services, Postnatal and Delivery (billed as "global" fee) Hospital Delivery charges Prenatal testing or treatment billed separately from "global" fee Postnatal visit or treatment billed separately from "global" fee	You pay 40% after deductible You pay 40% after deductible You pay 40% after deductible You pay 40% after deductible You pay 40% after deductible	You pay 50% after deductible You pay 50% after deductible You pay 50% after deductible You pay 50% after deductible You pay 50% after deductible
Autism Spectrum Disorders Diagnosis of Autism Spectrum Disorder Office Visit	You pay 40% after deductible	You pay 50% after deductible

BENEFIT INFORMATION NOTE: Covered Services are subject to applicable Annual Deductible, unless specifically waived.	IN-NETWORK (Based on Negotiated Rate) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Diagnostic testing	You pay 40% after deductible	You pay 50% after deductible
Treatment of Autism Spectrum Disorder (see "Comprehensive Benefits What the Policy Pays For" section for specific information about what services are covered)	You pay 40% after deductible	You pay 50% after deductible
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities.	You pay 40% after deductible	You pay 50% after deductible
Home Health Services Unlimited visits per Insured Person, per calendar year. Maximum 8 visits per day	You pay 40% after deductible	You pay 50% after deductible
Durable Medical Equipment	You pay 40% after deductible	You pay 50% after deductible
External Prosthetic Appliances Note: Wigs and Hair pieces are limited to one per year.	You pay 40% after deductible	You pay 50% after deductible
Hospice		
Inpatient	You pay 40% after deductible	You pay 50% after deductible
Outpatient	You pay 40% after deductible	You pay 50% after deductible
Dialysis		
Inpatient	You pay 40% after deductible	You pay 50% after deductible
Outpatient	You pay 40% after deductible	You pay 50% after deductible
Smoking Cessation Medical treatment (Prescription Drugs for smoking	You pay 40% after deductible	You pay 50% after deductible

BENEFIT INFORMATION NOTE: Covered Services are subject to applicable Annual Deductible, unless specifically waived.	IN-NETWORK (Based on Negotiated Rate) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
cessation treatment are covered under the Prescription Drug benefit)		
Medical Foods to treat inherited metabolic disorders Includes benefits for enteral nutrition for non-inherited disorders when medically appropriate.	You pay 50%, deductible waived	You pay 50% after deductible
Amino Acid Based formula to treat Eosinophilic Gastrointestinal Disorder	You pay 25%, deductible waived	You pay 50% after deductible
Chemotherapy Treatment: **Self-administered Injectable Chemotherapy Medication and Oral Chemotherapy Medication** Prescription self-administered injectable chemotherapy medication and oral chemotherapy medication.	You pay 40%, after deductible	You pay 50% after deductible
Mental, Emotional or Functional Nervous Disorders **Inpatient** (Includes Acute and Residential Treatment) **Outpatient** (includes individual, group, intensive outpatient and partial hospitalization) Outpatient Office Visit All other Outpatient Services	You pay 40% after deductible You pay 40% after deductible You pay 40% after deductible	You pay 50% after deductible You pay 50% after deductible You pay 50% after deductible

BENEFIT INFORMATION NOTE: Covered Services are subject to applicable Annual Deductible, unless specifically waived.	IN-NETWORK (Based on Negotiated Rate) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Substance Use Disorder **Inpatient** Detoxification/Rehabilitation (Includes Acute and Residential Treatment) **Outpatient** (includes individual, group, intensive outpatient and partial hospitalization)	You pay 40% after deductible	You pay 50% after deductible
Outpatient Office Visit	You pay 40% after deductible	You pay 50% after deductible
All other Outpatient Services	You pay 40% after deductible	You pay 50% after deductible

BENEFIT INFORMATION NOTE: Covered Services are subject to applicable Annual Deductible, unless specifically waived.	IN-NETWORK (Based on Negotiated Rate) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Organ and Tissue Transplants- (see benefit detail 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 Lifetime maximum payment of $10,000 **Other Cigna Network Facility <u>that is contracted for transplant services</u>** **<u>Other Cigna Network facility that is NOT contracted for transplant services or</u> Out-of-Network Facility**	You pay 0% after deductible You pay 40% after deductible Not Applicable	Not Applicable Not Applicable You pay 50% after deductible
Infusion and Injectable Specialty Prescription Medications and related services or supplies	You pay 40% after deductible	You pay 50% after deductible
Dental Care (other than Pediatric) Includes benefits for accident dental services that include cover for treatment of a fractured jaw as well as injury to sound natural teeth.	You pay 40% after deductible	You pay 50% after deductible
Bariatric Surgery Performed at a Cigna approved facility Performed at a facility that is not approved by Cigna	You pay 40% after deductible Not Covered	You pay 50% after deductible Not Covered

BENEFIT INFORMATION NOTE: Covered Services are subject to applicable Annual Deductible, unless specifically waived.	IN-NETWORK (Based on Negotiated Rate) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Hearing Aids Maximum of 1 device per ear, per Insured Person, per Year	You pay 40% after deductible	You pay 50% after deductible
Hearing Exam Maximum of 1 visit per Insured Person, per Year	You pay 40% after deductible	You pay 50% after deductible
Compression Garments Limited to one set upon diagnosis; coverage of up to 4 replacements per year.	You pay 40% after deductible	You pay 50% after deductible

BENEFIT INFORMATION	IN-NETWORK (Based on Cigna contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE COINSURANCE/COPAYMENT 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 Coinsurance shown in the Benefit Schedule.		
Cigna Retail Pharmacy Drug Program		
Tier 1: Retail Preferred Generic	You pay 40%, after deductible per Prescription or refill Up to a 90 day maximum supply	You pay 50%, after deductible per Prescription or refill Up to a 90 day maximum supply
Tier 2: Retail Non-Preferred Generic	You pay 40%, after deductible per Prescription or refill Up to a 90 day maximum supply	You pay 50%, after deductible per Prescription or refill Up to a 90 day maximum supply
Tier 3: Retail Preferred Brand	You pay 40%, after deductible per Prescription or refill Up to a 90 day maximum supply	You pay 50%, after deductible per Prescription or refill Up to a 90 day maximum supply
Tier 4: Retail Non-Preferred Brand	You pay 50%, after deductible per Prescription or refill Up to a 90 day maximum supply	You pay 50%, after deductible per Prescription or refill Up to a 90 day maximum supply
Tier 5: Retail Specialty	You pay 40%, after deductible per Prescription or refill Up to a 30 day maximum supply	You pay 50%, after deductible per Prescription or refill Up to a 30 day maximum supply
Retail Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive	You pay 0%, deductible waived per Prescription or refill Up to a 90 day maximum supply	You pay 50%, after deductible per Prescription or refill Up to a 90 day maximum supply

BENEFIT INFORMATION	IN-NETWORK (Based on Cigna contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE COINSURANCE/COPAYMENT HAS BEEN SATISFIED	
(including womens' contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative		
Cigna Mail Order Pharmacy Drug Program		
Tier 1: Mail Order Preferred Generic	You pay 40%,after deductible per Prescription or refill Up to a 90 day maximum supply	Not available
Tier 2: Mail Order Non-Preferred Generic	You pay 40%, after deductible per Prescription or refill Up to a 90 day maximum supply	Not available
Tier 3: Mail Order Preferred Brand	You pay 40%, after deductible per Prescription or refill Up to a 90 day maximum supply	Not available
Tier 4: Mail Order Non-Preferred Brand	You pay 50%, after deductible per Prescription or refill Up to a 90 day maximum supply	Not available
Tier 5: Mail Order Specialty	You pay 30%, after deductible per Prescription or refill Up to a 30 day maximum supply	Not available
Mail Order Pharmacy Preventive Drugs regardless of Tier Drugs designated by the Patient	You pay 0%, deductible waived per Prescription or refill Up to a 90 day maximum supply	Not available

BENEFIT INFORMATION	IN-NETWORK (Based on Cigna contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE COINSURANCE/COPAYMENT HAS BEEN SATISFIED	
Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative		

DEFINITIONS

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

Acceptable Third Party Payor means one or more of the following:

1. the Ryan White HIV/AIDS Program established under Title XXXVI of the Public Health Service Act;
2. an Indian tribe, tribal organization, or urban Indian organization;
3. a State or Federal government program; or
4. 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.

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

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

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

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

Brand Name Prescription Drug (Brand Name) means a Prescription Drug that has been patented and is only produced by one manufacturer.

Cigna We, Our, and Us mean Cigna (Cigna Health and Life Insurance Company), or an affiliate. Cigna is a licensed and regulated insurance company operating throughout the United States.

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

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

Cosmetic Surgery Cosmetic Surgery is:

- Surgery performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance.

Reconstructive Surgery is:

- surgery to correct the appearance of abnormal looking features or characteristics of the body caused by birth defects, Injury, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance.

Cosmetic Surgery Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

Coverage Area is the state of Arizona.

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

Covered Services are Medically Necessary services or supplies that:

(a) are listed in the benefit sections of this Policy, and
(b) are not specifically excluded by the Policy; and
(c) are provided by a Provider that is:

(i) licensed in accordance with any applicable Federal and state laws,

(ii) if a Hopital, accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another appropriately licensed organization, and

(iii) acting within the scope of the Provider's license and (if applicable) accreditation.

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

- Services related to watching or protecting a person;

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

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

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

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

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

Diabetes Pharmaceuticals & Supplies include, but are not limited to, test strips for blood glucose monitors; visual reading and urine test strips; tablets which test for glucose, ketones and protein; blood glucose monitors on Cigna's Prescription Drug List; lancets and lancet devices; insulin and insulin analogs, injection aids; including devices used to assist with insulin injection and needle less systems; syringes and needles, biohazard disposal containers, prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits.

Durable Medical Equipment is defined as items which:
- are designed for and able to withstand repeated use by more than one person;
- customarily serve a therapeutic purpose with respect to a particular Illness or Injury, as certified in writing by the attending medical provider;
- generally are not useful in the absence of illness or injury;
- are appropriate for use in the home;
- are of a truly durable nature, and
- are not disposable.

Such equipment includes, but is not limited to, crutches, hospital beds, wheel chairs, respirators, and dialysis machines.

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

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

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

Emergency Services means, with respect to an Emergency Medical Condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Essential Health Benefits: To the extent covered under this plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Expanded Access Telehealth Physician means a Physician who is part of a designated telehealth network, an organization contracted with Cigna to provide specific telehealth services.

Expanded Access Telehealth Service means a telehealth visit, initiated by the Insured Person and provided by an Expanded Access Telehealth Physician, for minor acute medical conditions such as a cold, flu, sore throat, rash or headache.

Note: the network that provides Expanded Access Telehealth Service is separate from the Plan network, and is only available for services detailed under “Expanded Access Telehealth Service” in the “Covered Services and Benefits” section of this Plan.

Experimental / Investigational Procedures: a drug, device or medical treatment or procedures is considered Experimental or Investigational if;

- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows it is the subject of ongoing phase I, II, III, or IV clinical trials or understudy to determine if maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the state or means of treatment or diagnosis (however, routine patient care costs associated with certain qualified clinical trials may be covered); or;
- reliable evidence shows that the consensus of the opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the stated means of treatment of diagnosis.

Reliable evidence means only; the published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure; or the medical informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

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

Family In-Network Out-of-Pocket Maximum: The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers that applies if You cover other Family Member(s). The Individual In-Network Out-of-Pocket paid by each Family Member counts toward satisfying the Family In-Network Out-of-Pocket Maximum. Each Insured Person can contribute up to the Individual In-Network Out-of-Pocket amount toward the Family In-Network Out-of-Pocket maximum. Once the Family In-Network Out-of-Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Deductible, Coinsurance or Copayments for medical or pharmacy services. Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Family In-of-Network Out-of-Pocket Maximum and will always be paid by You. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. Information about non-compliance penalties follows the Family Out-of-Pocket Maximum information in the Benefit Schedule under “Prior Authorization Program”.

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

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

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

Federal-facilitated Marketplace means a governmental agency or non-profit entity that meets the applicable standards and makes qualified health plans available to qualified individuals and employers and is established and operated within a State by the Secretary under section 1321(c)(1) of the Affordable Care Act.

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

Free-Standing Outpatient Surgical Facility
The term Free-standing Outpatient Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

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

Habilitative Services means health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

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

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

Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses; or

- an institution which qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital, and a provider of services under Medicare, if such institution is accredited as a hospital for the appropriate treatment and/or diagnosis by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: (a) specializes in treatment of mental health and substance use disorder or other related Illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency;

The term Hospital will not include any institution or facility in which a significant portion of the activities include rest, recreation, leisure, or any other services that do not consist exclusively of Covered Services.

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

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

Individual In-Network Out-of-Pocket Maximum: Once the Individual In-Network Out-of-Pocket Maximum has been met for the Year, for Covered Services received from Participating Providers, You will no longer have to pay any Deductibles, Copayment or 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 Individual In-Network Out-of-Pocket Maximum and will always be paid by You. The Individual In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Deductibles, Copayments and Coinsurance for medical services incurred from Participating Providers. The amount of the Individual In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

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

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

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

Inherited Metabolic Disorder means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the new born screening program as prescribed by Arizona statute; includes benefits for enternal nutrition for non-inherited disorders when medically appropriate.

Injury means an accidental bodily injury.

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

Institution means an establishment that furnishes food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

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

Marketplace means a state-based Marketplace, a state partnership Marketplace, or a federally-facilitated Marketplace, as the case may be.

Maximum Reimbursable Charge

The Maximum Reimbursable Charge for Emergency Services delivered in the Emergency department of a Hospital is determined based on the greatest of:

- A percentile or percentage of charges made by providers of such service or supply in the geographic area where it is received as compiled in a nationally-recognized database that uses generally accepted industry standards and practices for determining the customary and reasonable billed charge for a service, and that fairly and accurately reflects the market rate; or
- The median amount negotiated with In-Network Cigna Providers for the same services; or
- The amount Medicare would pay for the same or similar service within the geographic market.

The Maximum Reimbursable Charge for all other Covered Services is determined based on the least of:

- The provider's normal charge for a similar service or supply; or
- A percentile or percentage of charges made by providers of such service or supply in the geographic area where it is received as compiled in a nationally-recognized database that uses generally accepted industry standards and practices for determining the customary and reasonable billed charge for a service, and that fairly and accurately reflects the market rate; or
- The median amount negotiated with In-Network Cigna Providers for the same services; or
- The amount Medicare would pay for the same or similar service within the geographic market.

Medicaid
The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medical Foods are Modified Low Protein Foods and Metabolic Formula.

Medically Necessary or Dentally Necessary services or supplies are those that are determined by the Medical Director to be **all** of the following:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical or dental condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical or dental condition.
- Within generally accepted standards of good medical practice within the community of qualified professionals.
- Not primarily for the convenience of any Insured Person, Physician, or another Provider's.
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.
- The most appropriate procedure, supply, equipment or service which can be safely provided and that satisfies the following requirements:
    i) Must have been proven by scientific studies published in peer-reviewed medical literature to be associated with beneficial health outcomes, demonstrating that the expected health benefits are clinically significant and produce a greater likelihood of benefits, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and
    ii) Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    iii) For hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The fact that a Provider prescribed, ordered, recommended or approved a service, supply, treatment or Confinement does not in and of itself make it Medically Necessary or Dentally Necessary or a Medical or Dental Necessity.

Medicare The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Medication Synchronization means the coordination of medication refills for a patient taking two or more medications for a chronic condition that are being dispensed by a single contracted Pharmacy to facilitate the synchronization of the patient's medications for the purpose of improving medication adherence
This policy will prorate the cost sharing rate for a Prescription Drug that is dispensed for less than the standard refill amount if the insured requests:

- enrollment into a Medication Synchronization program; and
- less than the standard refill amount for the purpose of synchronizing the insured's medications.

Mental, Emotional or Functional Nervous Disorders are neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Metabolic Formula means foods that are all of the following: (a) formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and (d) essential to a person's optimal growth, health and metabolic homeostasis.

Modified Low Protein Foods means foods that are all of the following: (a) formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and (d) essential to a person's optimal growth, health and metabolic homeostasis.

Negotiated Rate is the rate of payment that has been negotiated with a Participating Provider for Covered Services.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out-of-Network Provider) is a Provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on Maximum Reimbursable Charges which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

Office Visit means a visit by the Insured Person, who is the patient, to the office of a Physician during which one or more of only the following 3 specific services are provided:

- History (gathering of information on an Illness or Injury)
- Examination
- Medical Decision Making (the Physician's diagnosis and Plan of treatment)

This does not include other services (e.g. x-rays or lab services) even if performed on the same day.

Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing facilities, rehabilitation Hospitals and subacute facilities.

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

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

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

Patient Protection and Affordable Care Act of 2010 (PPACA)

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

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

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

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

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

Physician is a Physician licensed to practice medicine or any other practitioner who is licensed and recognized as a provider of health care services in the state in which the Insured Person resides; and provides services covered by the Policy that are within the scope of his or her licensure.

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

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

Policy Year is defined as a 12-month period that begins each January 1 at 12:01 a.m. Eastern Time.
Note: Deductible and other benefit accumulations accumulate on a Calendar Year rather than Policy Year basis.

Prescription Drug is

- a drug which has been approved by the Food and Drug Administration for safety and efficacy;
- certain drugs approved under the Drug Efficacy Study Implementation review; or
- drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List is a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated. You can view the drug list on www.myCigna.com.

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

Preventive Drugs on the Cigna Preventive Drug List are drugs or medications when taken by an Insured Person who has developed risk factors for a disease or condition listed below prior to onset of the disease or condition, or to prevent the reoccurrence of the disease or condition from which an Insured Person has fully recovered:

- hypertension
- high cholesterol
- diabetes
- asthma
- osteoporosis
- stroke
- prenatal nutrient deficiency

For example, the treatment of high cholesterol with cholesterol-lowering medications (e.g., statins) to prevent heart disease or the treatment of recovered heart attack or stroke victims with Angiotensin-converting Enzyme (ACE) inhibitors to prevent a reoccurrence, constitute Cigna-designated preventive care.

Primary Care Physician is a Physician:

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

Prior Authorization: means the approval for certain medical services or Prescription Drugs and Related Supplies that a Participating Provider must request and receive, from Cigna for medical services and from the Pharmacy and Therapeutics Committee for Prescription Drugs and Related Supplies, before the services are rendered, or the Prescription Drugs are Prescribed, in order for those medical services or Prescription Drugs and Related Supplies to be eligible for benefits under this Plan. You can identify the Prescription Drugs and Related Supplies that require Prior Authorization on the Prescription Drug List at www.myCigna.com.

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

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

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

Provider means a Hospital, a Physician or any other health care practitioner (i) licensed in accordance with any applicable Federal and state laws, (ii) accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another organization, if approved by Cigna, and (iii) acting within the scope of the practitioner's license and accreditation.

Qualified Health Plan Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by a market place, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A Qualified Health Plan will have a certification by each marketplace in which it is sold.

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

Related Supplies are diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes, inhalers, inhaler spacers for the management and treatment of pediatric asthma and other conditions, diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills); disposable needles and syringes needed for injecting covered drugs and supplements.

Relevant Information
Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of or guidance with respect to the Policy concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Self-administered Injectable Drugs means FDA approved medications which a person may administer to himself/herself by means of intramuscular, intravenous or subcutaneous injection. This does not include insulin prescribed for use by the Insured Person.

Service Area means the area where in which Cigna has a Participating Provider network for use by this Plan. To locate a Provider who is participating in the Network used by this Plan, call the toll-free number on the back of Your ID card, or check www.mycigna.com and click on “find a Doctor, Dentist or Facility”.

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

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

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

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

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

Special Limits are limits applied to certain Covered Expenses in the form of an Annual, number of visits, or per number of days maximum. We will not apply any amount in excess of the Special Limit amount to any Deductible. Even when an Out of Pocket Maximum has been reached, We will still apply the Special Limits to the applicable Covered Expenses. The expenses you incur which exceed specific maximums described in this Policy will be Your responsibility. The Special Limits are described in the Benefit Schedule and in the section of this Policy titled “How The Policy Works”.

Specialty Medication means a Generic or Brand Name Prescription Drug that meets both of the following criteria, subject to applicable law:

(A) The drug is either derived from biotechnology processes, which use tissue culture, living cells, or cellular enzymes; or is a small molecule drug (organic compound, binds to a protein, nucleic acid, or polysaccharide); and

(B) In general meets at least 3 of the following attributes:

1. Targets the underlying disease pathology;
2. Modifies disease sequel;
3. Targets conditions that are rare, chronic, and costly;
4. Requires close supervision and monitoring of therapy for safety and effectiveness;
5. There is an available genetic test to ascertain its efficacy within a defined population.

The fact that a drug is considered a Specialty Medication based on the above criteria does not necessarily determine the tier assignment of the Specialty Medication, or whether the Specialty Medication is covered under the medical benefit or prescription drug benefit of this Policy.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Step Therapy is a type of Prior Authorization. Cigna may require an Insured Person to follow certain steps before covering some Prescription Drugs and Related supplies, including Specialty Medications. We may also require an Insured Person to try similar Prescription Drugs and Related Supplies, including Specialty Medications, that have been determined to be safe, effective, and more cost effective for most people that have the same condition as the Insured Person. The Prescription Drugs and Related Supplies that require Step Therapy can be identified on the Prescription Drug List at www.myCigna.com.

Telemedicine Medical Service means the interactive use of audio, video or other electronic media for the purpose of diagnosis, consultation or treatment; does not include the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail.

Terminal Illness is an illness due to which a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

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

Who Is Eligible For Coverage?

Eligibility Requirements

This Policy is for residents of the state of Arizona. 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 applications:

- 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 Arizona; and
- You live in the Coverage Area in which You are applying and intend to continue living there for the entire period for which enrollment is sought; and
- You are not incarcerated other than incarceration pending the disposition of charges; and
- and You do not reside in an Institution, as defined by federal law; and
- You have submitted a completed and signed application for coverage and have been accepted in writing by Us.
- Other Insured Persons may include the following Family Member(s): Your lawful spouse.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, or Your spouse's unmarried children who are enrolled as dependents and who are incapable of self-support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance, will continue to be covered as dependents. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually after the two year period following the child's attainment of the limiting age. Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's Newborn children are automatically covered for the first 31 days of life. To continue coverage past that time You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date of birth, and pay any additional premium. Coverage for a newborn dependent child enrolled within 61 days of birth will be retroactive to the date of the child's birth.
- An adopted child, including a child for whom the application and approval procedures for adoption pursuant to state law have been completed is automatically covered for Illness or Injury for 31 days from either the date of the final decree of adoption or the date a child is placed in the custody of the Insured, pursuant to an interim court order of adoption vesting temporary care of the child in the Insured regardless of whether the adoption has become final. To continue coverage, You must enroll the child as an Insured Person by notifying Us in writing within 31 days after either the date of placement or the final decree of Adoption, and pay any additional premium.

- If a court has ordered an Insured to provide coverage for an eligible child (as defined above) coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage past that time You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the court order date, and pay 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.

When Can I Apply?

Application to Enroll or Change Coverage

The Patient Protection and Affordable Care Act of 2010 (PPACA) specifies that an eligible person must enroll for coverage or change plans during the annual Open Enrollment Period. Persons who fail to enroll or change plans during the Open Enrollment Period must wait until the next Open Enrollment Period to enroll in a plan or to change plans. However, if a person experiences a triggering event as described below, the triggering event starts a 60-day Special Enrollment Period during which an eligible person can enroll and an Insured Person can add dependents and change coverage.

The Open Enrollment Period and Special Enrollment Period are explained below.

Annual Open Enrollment Period

The Annual Open Enrollment Period is a specified period of time each Year during which individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another.

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

Your coverage under this Policy will then become effective upon the earliest day allowable under federal rules for that Year's open enrollment period. **Note: If You do not apply to obtain or change coverage during the Annual Open Enrollment Period, You will not be able to apply again until the following Year's Annual Open Enrollment Period unless You qualify for a special enrollment period as described below.**

Special Enrollment Periods

A special enrollment period occurs when a person experiences a triggering event.

If You experience one of the triggering events listed below, You can enroll for coverage and enroll Your eligible Dependent(s) during a special enrollment period instead of waiting for the next Annual Open Enrollment Period.

Triggering events for a special enrollment period are:

- The qualified individual, or his or her dependent, which was not previously a citizen, national, or lawfully present individual gains such status; or
- The qualified individuals or his or her dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction; or
- The enrollee or, his or her dependent adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee; Newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for cost-sharing reductions;
  The qualified individual who is an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; or
- The qualified individual or enrollee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide; or
- An eligible individual, and any dependent(s), loses his or her minimum essential coverage; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gaining or becoming a dependent through marriage, birth adoption or placement for adoption, placement in foster care; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or

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

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

- In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care;

- In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, coverage is effective for a qualified individual or enrollee on the first day of the following month.

For all other triggering events the effective dates are:

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

Specific Causes for Ineligibility

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

- When premiums are not paid according to the due dates and grace periods described in the Premium Section.
- For the spouse, when the spouse is no longer married to the Insured;
- For You and Your family Member(s) when you no longer meet the requirements listed in the Eligibility Requirements section;
- The date the Policy terminates.

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 ineligibility due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured 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.

Continuity of Care

There may be instances in which Your PCP or network specialist ceases to be a Participating Physician. In such cases, You will be notified and provided assistance in selecting a new PCP or identifying a new network specialist to continue providing Covered Services. However, in special circumstances, You may be able to continue seeing Your PCP or network specialist, even though he or she is no longer affiliated with Cigna.

Continuity of Care allows You to receive services at In-network coverage levels if Your PCP is leaving the network and You (i) are receiving an on-going course of treatment for a life-threatening disease or condition, or a degenerative or disabling disease or condition, or (ii) have entered Your second trimester of pregnancy as of the effective date of Your enrollment. You may be eligible to receive continuity of care from that non-participating provider for a transitional period of up to ninety (90) days, or the post-partum period directly related to the delivery of Your child. Such continuity of care must be approved in advance by Cigna, and Your doctor must agree to accept our reimbursement rate and to abide by Cigna's policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider who ceases to be a Participating Provider will not be available, such as when the provider loses his/her license to practice or retires.

How The Policy Works

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

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

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

Benefit Schedule

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

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

Participating Hospitals, Participating Physicians and Other Participating Providers

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

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

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

Covered Expense for services provided by a Non-Participating Provider will not exceed the lesser of actual billed charges, or a Maximum Reimbursable Charge. These services may be subject to additional penalties and/or Deductibles. Additional penalties used here refers to penalties for non-compliance with prior authorization requirements. The Prior Authorization requirements are set forth in the first section of the Policy; penalties are outlined at the end of the section titled "How the Policy Works", and penalty amounts are included in the Benefit Schedule for each Policy.

Special Circumstances

Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule in certain circumstances as provided below:

- **Hospital Emergency Services**

Emergency Services for an Emergency Medical Condition will be paid at the Participating Provider benefit schedule. Once the patient is stabilized and he/she can be transferred to a Participating Hospital, medical payment will be reduced to the Non-Participating Provider benefit schedule if the Insured Person continues inpatient stay at a Non-Participating Hospital when his or her medical condition permits transfer to a Participating Hospital.

- **Physician or Other Provider Emergency Services**

  Covered Expense will be paid at the Participating Provider benefit schedule for the initial care of an Emergency Medical Condition.

- **Availability of Preferred Providers**
  Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule when the services of a Participating Provider are unavailable within the Service Area. Refer to the 'Definitions' section of this Policy for a description of the Service Area.

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before benefits are available. Deductibles apply to all Covered Expenses as described in the Definitions section of the Policy, unless expressly stated otherwise in the Benefit Schedule. Deductibles do not include any amounts in excess of Maximum Reimbursable Charges, Prescription Drug Copays, Copayments, any penalties or expenses that are not Covered Expenses.
Deductibles will be applied in the order in which an Insured Persons claims are received and processed by Us, not necessarily in the order in which the Insured Person receives the service or supply.

If the Insured Person submits a claim for services which have a maximum payment limit and the Deductibles are not satisfied, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward any applicable Deductible.

In-Network Deductible
The In-Network Deductible is stated in the Benefit Schedule. The Deductible is the amount of Covered Expenses You must pay for **any** Covered Services (except as specifically stated otherwise in the Benefit Schedule) incurred from Participating Providers each Year before any benefits are available.

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

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

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

Out-of-Pocket Maximum(s)

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

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

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

Special Limits

We will not apply any amount in excess of the Special Limit amount to any Deductible, **Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits on certain Covered Expenses described in the Benefit Schedule. Please see the Benefit Schedule for details on Annual, Lifetime or payment Maximums which may apply to these specific Benefits.**

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

Non-Compliance Penalties

A Penalty is an amount of Covered Expenses that is:

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

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

Penalties will apply under the following circumstances:

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

Penalties are applied before any benefits are available.

Comprehensive Benefits: What the Policy Pays For

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

To be eligible for benefits under this Policy, the Provider must be appropriately licensed according to state and local laws and accredited to provide services within the scope of the Provider's license and accreditation.

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

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

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

If You are an inpatient in a Hospital, Skilled Nursing Facility or inpatient rehabilitation facility on the day Your coverage begins, We will pay benefits for Covered Services that You receive on or after Your first day of coverage related to that inpatient stay as long as You receive Covered Services in accordance with the terms of this Policy. These benefits are subject to any prior carrier's obligations under state law or contract.

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

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

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

- Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
- Birthing Centers
- Outpatient services and supplies including those in connection with Emergency Services, outpatient surgery and outpatient surgery performed at a Free-Standing Outpatient Surgical Facility.
- Diagnostic/Therapeutic Lab and X-rays.
- Anesthesia and Inhalation Therapy.
- Private hospital rooms and/or private duty nursing are covered if determined to be medically appropriate by the Plan. Private duty nursing in an inpatient setting is appropriate when skilled nursing is not available from the facility.

Payments of Inpatient Covered Expenses are subject to these conditions:

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

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

Services and Supplies Provided by a Skilled Nursing Facility

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

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

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

Note: No benefits will be provided for:

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

Hospice Services

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

The Policy covers hospice care services which are provided under an approved hospice care program when provided to an Insured Person who has been diagnosed by a Participating or Non-Participating Provider as having a terminal illness with a prognosis of six (6) months or less to live. Hospice care services include inpatient care; outpatient services; professional services of a Physician; services of a psychologist, social worker or family counselor for individual and family counseling; and home health services.

Hospice care services do not include the following:
1. services of a person who is a member of Your family or Your dependent's family or who normally resides in your house or your dependent's house;
2. services and supplies for curative or life prolonging procedures;
3. services and supplies for which any other benefits are payable under the Plan;
4. services and supplies that are primarily to aid You or Your dependent in daily living;
5. services and supplies for respite (custodial) care; and
6. nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

Hospice care services are services provided by a Participating Hospital; a Participating skilled nursing facility or a similar institution; a Participating home health care agency; a Participating hospice facility, or any other licensed facility or agency under a Medicare approved hospice care program.

A hospice facility is a Participating institution or portion of a facility which primarily provides care for terminally ill patients; is a Medicare approved hospice care facility; meets standards established by the Plan; and fulfills all licensing requirements of the state or locality in which it operates.

Professional and Other Services

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

This Policy provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- Services of an anesthesiologist or an anesthetist;
- Outpatient diagnostic radiology and laboratory services;
- Radiation therapy, chemotherapy and hemodialysis treatment;
- Surgical implants, except for cosmetic and dental;
- Surgical procedures for sterilization (i.e., vasectomy, and or tubal ligations);
- Prostheses/Prosthetic appliances and devices, artificial limbs or eyes;
- Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.
- The first pair of contact lenses or the first pair of eyeglasses when required as a result of eye surgery;
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products
- Spinal manipulation therapy
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification and;
- Diagnostic services rendered for infertility evaluation are covered. Any medical treatment and/or prescription related to infertility once diagnosed are excluded by the Plan.

- Ostomy Supplies are supplies which are medically appropriate for care and cleaning of a temporary or permanent ostomy. Covered supplies include, but are not limited to pouches, face plates and belts, irrigation sleeves, bags and catheters, skin barriers, gauze, adhesive, adhesive remover, deodorant, pouch covers, and other supplies as appropriate.

- Family Planning Services (Contraception and Voluntary Sterilization): covered family planning services including:
  1. Medical history;
  2. Physical examination;
  3. Related laboratory tests;
  4. Medical supervision in accordance with generally accepted medical practice;
  5. Information and counseling on contraception;
  6. Implanted/injected, appliances and oral contraceptives; and
  7. After appropriate counseling, Medical Services connected with surgical therapies (vasectomy or tubal ligation).

- Rental or purchase of medical equipment and/or supplies that meet all of the following requirements:
  - Ordered by a Physician;
  - Of no further use when medical need ends;
  - Usable only by the patient;
  - Not primarily for comfort or hygiene;
  - Not for environmental control;
  - Not for exercise; and
  - And manufactured specifically for medical use.

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

Cigna determines whether the item meets these conditions.

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

Bariatric Services

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

This Policy provides benefits for the following bariatric surgery procedures:
- open roux-en-y gastric bypass (RYGBP),
- laparoscopic roux-en-y gastric bypass (RYGBP),
- laparoscopic adjustable gastric banding (LAGB),
- open biliopancreatic diversion with duodenal switch (BPD/DS),
- laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS), and
- laparoscopic sleeve gastrectomy (LSG)

Only if all the following criteria are met:

- The patient must have a body-mass index (BMI) ≥35, and
- have at least one co-morbidity related to obesity, and
- had previously unsuccessful with medical treatment for obesity. The following medical information must be documented in the patient's medical record:

Active participation within the last two years in one physician–supervised weight-management program for a minimum of six months without significant gaps. The weight-management program must include monthly documentation of all of the following components:

- Weight
- Current dietary program
- Physical activity (e.g., exercise program)

In addition, the procedure must be performed at an approved Center of Excellence facility that is credentialed by Cigna to perform bariatric surgery.

The Insured Person must be 18 years or older, or have reached full expected skeletal growth.

If treatment was directly paid or covered by another plan medically necessary adjustments will be covered.

The following bariatric procedures are not covered:

- Open vertical banded gastroplasty;
- Laparoscopic vertical banded gastroplasty;
- Open sleeve gastrectomy;
- Open adjustable gastric banding.

Ambulance Services

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)
This Policy provides benefits for Covered Expenses incurred for the following ambulance services:

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

Ambulance transportation is covered for emergency situations, to the nearest facility capable of handling the emergency or Medically Necessary transfers from one medical facility to another.

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

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

This Policy provides benefits for Covered Expenses incurred for the following short-term rehabilitative services:

- Therapeutic use of heat, cold, exercise, electricity or ultraviolet light; or
- Manipulation of the spine; or
- Massage to improve circulation, strengthen muscles, encourage return on range of motion, as part of treatment for an Illness or Injury; and
- Services for the necessary care and treatment of loss or impairment of speech.

Benefits are provided up to any maximum number of visits shown in the Benefit Schedule. For the purposes of this benefit, the term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided.

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

Special Note:
Additional visits for Physical, Occupational and Speech Therapy, beyond any maximum shown in the Benefit Schedule, may be covered following severe trauma such as:

- An inpatient hospitalization due to severe trauma, such as spinal Injury or stroke; and
- Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment; and
- Cigna authorizes this in advance.

Services for Pulmonary and Cardiac Rehabilitation

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

This Policy provides benefits for Covered Expenses incurred for pulmonary rehabilitation, and for:

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

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

Habilitative Services

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

This Policy provides benefits for Covered Expenses services designed to assist You in developing a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame are payable as stated in the Benefit Schedule.

Benefits for Covered Expenses will be provided for Medically Necessary care and treatment of loss or impairment of speech, stated in the Benefit Schedule.

This Policy provides benefits for Covered Expenses incurred for the following short-term rehabilitative services, Physical Therapy, Occupational Therapy, and Speech Therapy:

- Therapeutic use of heat, cold, exercise, electricity or ultraviolet light; or
- Manipulation of the spine; or
- Massage,
- To improve circulation, strengthen muscles, encourage return on range of motion, as part of treatment for an Illness or Injury; and
- Services for the necessary care and treatment of loss or impairment of speech; and
- Services designed to assist a child to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame.

Benefits are provided up to any maximum number of visits shown in the Benefit Schedule. For the purposes of this benefit, the term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided.

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

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

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

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

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

- Services must be for the treatment of a Mental, Emotional or Functional Nervous Disorder, or Substance Use Disorder.
- The Insured Person must be under the direct care and treatment of a Physician for the condition being treated.
- Services must be those which are regularly provided and billed by a Hospital or a Physician.
- Services are covered only for the number of days or visits which are Medically Necessary to treat the Insured's condition.
- Inpatient services must be received in a Hospital or day treatment center for inpatient treatment.

Covered services include, but are not limited to:

- inpatient mental health services;
- outpatient treatment of conditions such as: anxiety or depression which interferes with daily functioning;
- emotional adjustment or concerns related to chronic conditions, such as psychosis or depression;
- neuropsychological testing; emotional reactions associated with marital problems or divorce;
- child/adolescent problems of conduct or poor impulse control; affective disorders;
- suicidal or homicidal threats or acts; eating disorders;
- or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention), outpatient testing/assessment, and medication management when provided in conjunction with a consultation;
- coverage for a psychiatric assessment and stabilization in an Emergency Room.

Dental Care

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

This Policy provides benefits for dental care for accidental dental services to natural teeth, coverage for treatment of a fractured jaw and dental confinements/anesthesia required due to a hazardous medical condition and is subject to the following:

- no benefits are available to replace or repair existing dental prostheses even if damaged in an eligible accidental Injury; and
- damage to natural teeth due to chewing or biting is not considered an accidental Injury under this Policy.

This Policy provides benefits for hospital confinement and/or anthesia related to dental care when an Insured Person's medical condition makes such confinement or aesthesia Medically Necessary.

Anesthesia for Dental Procedures

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

- an Insured Person at any age who is developmentally disabled; or
- an Insured Person whose health is compromised and general anesthesia is Medically Necessary.

Hearing Aids

This Policy provides benefits for hearing aid devices to the limit shown in the benefit schedule.
The following services are covered:

- New or replacement hearing aids no longer under warranty (Pre-Certification/Prior Authorization required);
- Cleaning or repair;
- Batteries for cochlear implants.

Pregnancy and Maternity Care

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

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

All comprehensive benefits described in this Plan are available for maternity services.
Comprehensive Hospital benefits for routine nursery care of a newborn child are available so long as the child qualifies as an Eligible Dependent as defined in 'Conditions of Eligibility' in the section of this Plan titled "Who is Eligible for Coverage?".
Maternity care benefits also apply to the natural mother of a newborn child legally adopted by you in accordance with the Plan adoption policies. These benefits do not apply to the newly born child of an Eligible Dependent daughter unless placement of that child with You is confirmed through a court order or legal guardianship.

The Plan covers charges for Eligible Expenses incurred by the birth mother for the delivery of Your adopted child only to the extent that they exceed the birth mother's coverage, if any, provided:
1. That child is legally adopted by you within one year from date of birth;
2. You are legally obligated to pay the cost of the birth;
3. You enroll the child as a dependent within 60 days of the adoption; and
4. You choose to file a claim for such expenses subject to all other terms of these medical benefits.

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

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

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

Coverage for reconstructive surgery to restore a bodily function or to correct a deformity caused by Injury, birth abnormalities or congenital defect of a Newborn child, will not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the Policy definition of "Medically Necessary." Benefits will be payable on the same basis as any other Illness or Injury under the Policy.

Preventive Care Services

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

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

- Routine physical exams.
- Well Child exams and immunizations.
- Annual Pap test, Prostate Specific Antigen (PSA) and Digital Rectal Examination (DRE).
- Mammograms
- United States Preventive Services Task Force (USPSTF) for services rated "A" or "B", Advisory Committee on Immunization Practices (HRSA) recommended wellness screening laboratory tests and procedures, and radiology procedures in connection with the examination.
- Routine Immunizations, including flu shots, tetanus shots, evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and

Services Administration; and

- For women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Annual routine eye screening for adults, conducted by a physician as part of the annual preventive health examination.
- Diabetes Self-Management Training
- Counseling/ educational services for breastfeeding/lactation
- Physician counseling regarding alcohol misuse, preventive medication, obesity, nutrition, tobacco cessation and depression/psychological, genetic, healthy diet, preventive medication, sexually transmitted infections, domestic violence, skin cancer; preventive counseling and educational services.

Detailed information is available at: www.healthcare.gov

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

Genetic Testing

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

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

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

Genetic counseling is covered if an Insured Person is undergoing approved genetic testing or if an Insured Person has an inherited disease and is a potential candidate for genetic testing.

Autism Spectrum Disorders

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

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

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

1) Treatment for Autism Spectrum Disorders shall include the following care prescribed, provided, or ordered for an individual diagnosed with an Autism Spectrum Disorder by a physician licensed to practice medicine or
2) a certified, registered, or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be medically necessary and ordered by a physician licensed to practice medicine.

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

Covered Services include:

- Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
- Psychological care, meaning direct or consultative services provided by a licensed psychologist.
- Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.
- Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:
  a. self-care and feeding,
  b. pragmatic, receptive, and expressive language,
  c. cognitive functioning,
  d. applied behavior analysis, intervention, and modification,
  e. motor planning, and
  f. sensory processing.

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

Organ and Tissue Transplants

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

Coverage is provided for human organ and tissue transplant services at designated facilities throughout the United States. Coverage is also provided for human organ and tissue transplant services at other Cigna In-Network facilities contracted with Cigna for transplant services and Out-of-Network facilities. Transplant services include solid organ and bone marrow/stem cell procedures. This coverage is subject to the following conditions and limitations.

Coverage is provided for both the recipient and donor of a covered transplant as follows:

1. If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own program.
2. If You are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this plan will be provided for both You and the donor. In this case, payments made for the donor will be charged against Your benefits.
3. If You are the donor for the transplant and no coverage is available to You from any other source, the benefits under this plan will be provided for You. However, no benefits will be provided for the recipient.

Coverage will be provided for:

1. Inpatient and Outpatient Covered Services related to the transplant surgery. Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, kidney/liver, liver, lung, pancreas or intestinal, including small bowel, small bowel/liver or multivisceral.
2. The evaluation, preparation and delivery of the donor organ.
3. The removal of the organ from the donor. Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if medically necessary. Costs related to the search and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Reimbursement may not be denied for an otherwise Covered Expense incurred for any organ transplant procedure solely on the basis that such procedure is deemed Experimental or Investigational unless supported by the determination of the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services that such procedure is either Experimental or Investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable. Transplant services received at In-Network Provider facilities specifically contracted with Cigna for those Transplant services are payable at the In-Network level.

NOTE: Some In-Network Provider facilities are NOT contracted with Cigna to provide transplant services. If You elect to have transplant services at an In-Network facility that is not contracted with Cigna to provide transplant services, those services would be covered at the Plan's Out-of-Network benefit level. For more information on whether an In-Network facility is contracted with Cigna to provide transplant services, contact Your Cigna case manager or call the number on Your ID card.

Transplant services received at any other facilities, including Out-of-Network Providers and In-Network Providers not specifically contracted with Cigna for Transplant services, are covered at the Out-of-Network level.

Transplant Travel Services

Coverage is provided for transportation and lodging expenses incurred by You in connection with a pre-approved organ/tissue transplant, that if reimbursed by Cigna would be characterized by the Internal Revenue Service as taxable income pursuant to Publication 502, subject to the following conditions and limitations. Coverage is also provided for taxable expenses incurred for meals and food purchased in connection with a pre-approved organ/tissue transplant, subject to the following conditions and limitations. Benefits for transportation, lodging, food and meals are available to You only if You are the recipient of a pre-approved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility.

The term "recipient" includes an Insured Person receiving authorized transplant-related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the Member receiving the transplant will include Charges for:

- transportation to and from the transplant site (including Charges for a rental car used during a period of care at the transplant facility);
- lodging while at, or traveling to and from the transplant site; and
- food and meals consumed while at, or traveling to and from the transplant site.

In addition to You being covered for the Covered Services associated with the items above, such Covered Services will also be considered covered travel expenses for one companion to accompany You. The term "companion" includes Your spouse, a member of Your family, Your legal guardian, or any person not related to You, but actively involved as Your caregiver who is at least eighteen (18) years of age.

The following are specifically excluded travel expenses:

- any expenses that if reimbursed would be taxable income except food and meals;
- travel costs incurred due to travel within less than sixty (60) miles of Your home;
- laundry bills;
- telephone bills;
- alcohol or tobacco products; and
- charges for airline transportation that exceed coach class rates.

Note: Transplant travel benefits are not available for cornea transplants. Transplant Travel Services are only available when the Insured Person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available where the Insured Person is a donor.
Travel expenses for organ and tissue transplants are limited to any maximum shown in the Schedule of Benefits.

Clinical Trials

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

Benefits are payable for all routine patient care costs related to an approved clinical trial provided by a Participating Provider**,** including Phases I through IV, for an Insured Person who meets the following requirements:

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

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

The clinical trial must meet the following requirements:

- The study or investigation must meet 1, 2 or 3 below :
  1. Be approved or funded by any agencies or entities authorized by federal law to conduct clinical trials:
     A. the National Institutes of Health;
     B. the Centers for Disease Control and Prevention;
     C. the Agency for Health Care Research on Quality;
     D. the Centers for Medicare & Medicaid Services;
     E. cooperative group or center of any of the entities named in (A) through (D); or the Department of Defense or the Department of Veterans Affairs;
     F. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

G. Any of the following if the "Conditions For Departments" described below are met:

(i) The Department of Veterans Affairs.
(ii) The Department of Defense.
(iii) The Department of Energy.

Conditions for Departments – a study or investigation conducted by a Department must be reviewed and approved through a system of peer review that the Secretary of Health and Human Service determines:

A. is comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and
B. assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
C. A panel of experts within academic health institutions in Arizona for a cancer clinical trial conducted at an Arizona state institution.

2. Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or.
3 Involve a drug trial that is exempt from having such an investigational new drug application.

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

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

For clinical trials, routine patient costs do not include—

1. the investigational item, device, or service, itself;
2. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Compression Garments

Compression garments for treatment of lymphedema are limited to one set upon diagnosis. Coverage of up to four (4) replacements per calendar year, when determined to be medically necessary by Cigna and the compression stocking cannot be repaired or when require due to a change in the members physical condition.

Orally Administered Anticancer Medications

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

Benefits are payable for orally administered anticancer medications (that is, medications used to kill or slow the growth of cancerous cells) prescribed by a physician, on the same basis as benefits for intravenously administered anticancer mediations.

Treatment of Diabetes

Medical services for Diabetes are covered on the same basis as any other medical condition. This Policy provides benefits for Covered Expenses including outpatient Diabetes Self-Management Training and education, Diabetes Equipment and Diabetes Pharmaceuticals & Supplies for the treatment of Type 1 Diabetes, Type 2 Diabetes, and Gestational Diabetes Mellitus.

Charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
a. Medically Appropriate visits when diabetes is diagnosed;
b. Visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
c. Visits when reeducation or refresher training is prescribed by the Physician; and
d. Medical nutrition therapy (education) related to diabetes management.

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

Insulin preparations and glucagon, syringes and needles, test strips for glucose monitors and visual reading ketone strips and urine testing strips; insulin cartridges, insulin cartridges for the blind, drawing up devices and monitors for the visually impaired, injection aids, syringes and lancets including automatic lancing devices, Prescription oral agents used to control blood sugar and glucagon emergency kits; Glucagon emergency kits and alcohol swabs.

Treatment Received from Foreign Country Providers

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

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

Provider but any payment will be sent to the Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. The Insured Person at their expense is responsible for obtaining an English language translation of Foreign Country Provider claims and any medical records that may be required. Benefits are subject to all terms, conditions, limitations, penalties, Waivers, and exclusions of this Policy and will not be more than would be paid if the service or supply had been received in the United States.

Home Health Care

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

Services must be furnished by a Home Health Agency or a Visiting Nurses Association.
This Policy provides benefits for Covered Expenses for Home Health Care when an Insured Person is confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. **Home Health services are limited to a combined maximum number of visits each Year as shown in the Benefit Schedule.** If the Insured Person is dependent upon others for non-skilled care, custodial services and/or activities of daily living (e.g., bathing, eating, etc.), Home Health Care will be covered only during times when there is a family member or care giver present in the home to meet the Insured Person's non-skilled and/or custodial service's needs. Covered Services are limited to patient care that is determined to be Medically Necessary by Us. For purposes of this provision a Home Health Care visit is defined as up to 16 hours of Medically Necessary care per day. Multiple visits can occur in one day, with a visit defined as a period of 2 hours or less (e.g., maximum of 8 visits per day), and prescribed by a Physician in lieu of hospitalization. Home Health Care Services must be provided by one of the following providers:

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

Private hospital rooms and/or private duty nursing are only available during inpatient stays and determined to be medically appropriate by the Plan. Private duty nursing is available only in an inpatient setting when skilled nursing is not available from the facility.

Smoking Cessation

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

Mastectomy and Related Procedures

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

This Policy provides benefits for Covered Expenses for hospital and professional services for mastectomy and lymph node dissection for the treatment of breast cancer. Coverage includes treatment of physical complications of all stages of mastectomy, including lymphedemas, whether or not the mastectomy occurred while the Insured Person was covered under the Policy.

Benefits will be provided for Covered Expenses for inpatient Hospital care for no less than 48 hours following a mastectomy and for no less than 24 hours following a lymph node dissection for the treatment of breast cancer.

If the Insured Person elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Mastectomy bras/camisoles and external prosthetics that meet external prosthetic placement needs.

Coverage for reconstructive breast surgery will not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the Policy definition of "Medically Necessary." Benefits will be payable on the same basis as any other Illness or Injury under the Policy.

Treatment for TMJ (Temporomandibular Joint Dysfunction)

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

Medical services for TMJ are covered on the same basis as any other medical condition. ***Orthognathic Surgery: Orthgonothic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) are covered if approved as Medically Necessary.***

Medical Foods/Metabolic Supplements and Gastric Disorder Formula

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

Benefits are payable for medical foods, metabolic supplements and gastric disorder formula to treat Inherited Metabolic Disorders are paid on the same basis as any other medical condition.

Inherited Metabolic Disorders triggering Medical Food coverage are: (a) part of the newborn screening program as prescribed by Arizona statute; (b) involve amino acid, carbohydrate or fat metabolism; (c) have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and (d) require specifically processed or treated Medical Foods that are generally available only under the supervision and direction of a Physician or registered nurse

practitioner, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

For non-inherited disorders, enteral nutrition is considered Medically Necessary when the Insured Person has:

- A permanent non-function or disease of the structures that normally permit food to reach the small bowel; or
- A disease of the small bowel which impairs digestion and absorption of an oral diet consisting of solid or semi-solid foods.

Nutritional Evaluation

Nutritional evaluation and counseling from a Participating Provider is covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition/, including but not limited to:

- Morbid obesity
- Diabetes
- Cardiovascular disease
- Hypertension
- Kidney disease
- Eating disorder
- Gastrointestinal disorders
- Food allergies
- Hyperlipidemia

All other services for the purpose of diet control and weight reduction are not covered unless requires by a specifically identified condition of disease etiology. Services not covered include but not limited to: gastric surgery, intra oral wiring, gastric balloons, dietary formulae, hypnosis, cosmetics, and health and beauty aids.

Self-Management Training

Chronic Disease Self-Management Training from a Participating Provider is covered when it has a therapeutic role in the care of a diagnosed chronic disease/condition, including but not limited to:

- Morbid obesity
- Diabetes
- Cardiovascular disease
- Hypertension
- Kidney disease
- Eating disorders
- Gastrointestinal disorders
- Food allergies
- Hyperlipidemia

Eosinophilic Gastrointestinal Disorder

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

Benefits are payable for amino acid-based formula that is ordered by a Physician or registered nurse practitioner if:

- you have been diagnosed with an Eosinophilic Gastrointestinal Disorder;
- you are under continuous supervision of a Physician or registered nurse practitioner;
- there is a risk of a mental or physical impairment without the use of the formula.

Foot Orthotics

Foot Orthotic devices and inserts covered only for diabetes mellitus and any of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre- ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation.

Custom-molded shoes constructed over a positive model of the member's foot made from leather or other suitable material of equal quality containing removable inserts that can be altered or replaced as the member's condition warrants and have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.

External Prosthetic Appliances and Devices

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

This Policy provides benefits for Covered Expenses made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are Medically Necessary for the alleviation or correction of Injury, Illness or congenital defect, alopecia as a result of chemotherapy, radiation therapy, and second or third degree burns. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

Prostheses/prosthetic appliances and devices are defined as artificial devices designed to replace wholly or partly, an arm or leg. Prostheses/prosthetic appliances and devices include, but are not limited to:

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

The following are specifically **excluded** external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

Off Label Drugs

An Off label cancer drug that has been prescribed for a specific type of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration (U.S. FDA) will be covered if: (a) the drug is recognized as safe and effective for treatment of the specific type of cancer in one of the standard medical reference compendia or in medical literature. Coverage will also be provided for any medical services necessary to administer the drug.

Telemedicine

Benefits are payable for Telemedicine if the Health Care Service would be covered were it provided through in person consultation between the Insured Person and a health care provider and if provided to an Insured Person.

"Health Care Service" means services provided for the following conditions or in the following settings:

a) trauma

b) burn injuries

c) Cardiology diseases

d) infectious diseases

e) mental health disorders

f) neurologic diseases including strokes

g) dermatology diseases

"Telemedicine" means:

a) Means the interactive use of audio, video or other electronic media for the purpose of diagnosis, consultation or treatment.

b) Does not include the sole use of an audio only telephone, a video only system, a facsimile machine, instant messages or electronic mail.

Durable Medical Equipment

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

This Policy provides benefits for Covered Expenses incurred for rental or purchase of medical equipment and/or supplies that meet all of the following requirements:

- Are ordered by a Physician;
- Are of no further use when medical need ends;
- Are not primarily for comfort or hygiene;
- Are not for environmental control;
- Are not for exercise; and
- Are manufactured specifically for medical use.

Note: Medical equipment and supplies must meet all of the above guidelines in order to be eligible for benefits under this Policy. The fact that a Physician prescribes or orders equipment or supplies does not necessarily qualify the equipment or supply for payment. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative.

Cigna determines whether the item meets these conditions and whether the equipment falls under a rental or purchase category.

Rental charges that exceed the reasonable purchase price of the equipment are not covered, unless the equipment as previously been determined by Cigna to fall into a continuous rental category and require frequent maintenance and servicing.

Oxygen and the Oxygen Delivery System

Coverage of oxygen that is routinely used on an outpatient basis is limited to coverage within the Service Area. Oxygen Services and Supplies are not covered outside of the Service Area, except on an emergency basis.

Telehealth/Telemedicine Medical Services

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

Services for Telehealth/Telemedicine are covered under this Policy on the same basis as any other medical benefit. Please refer the "Definitions" section of this Policy for a complete description of the services.
Note: this benefit does not include Expanded Access Telehealth Services.

Expanded Access Telehealth Service

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

This Plan provides benefits for electronic visits with an Expanded Access Telehealth Physician. You can initiate a telephone, email or online video visit for treatment of minor acute medical conditions such as a cold, flu, sore throat, rash or headache without referral from Your PCP. You may access Expanded Access Telehealth Physicians by going to www.mycigna.com and click on Find a Doctor, Dentist or Facility; type "Telehealth/Telemedicine/eVisit under 'search criteria'.
If the Expanded Access Telehealth Physician feels Your condition cannot be optimally treated through remote contact, he or she will refer You to Your PCP for treatment or for referral to another Physician, or advise You to go to urgent care or an emergency room.

The following services are covered:

- Assessment of the condition, including history and current symptoms
- Diagnosis of the condition
- Prescribing medication to treat the condition.
- Providing discharge instructions through email.

You have the option to have records from each Expanded Access Telehealth Physician visit sent to Your regular Physician.

Exclusions And Limitations: What Is Not Covered By This Policy

Excluded Services

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

- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed in this Policy as Covered Services**.
- Services for **treatment of complications of non-covered procedures** or services.
- Services or supplies that are **not Medically Necessary**.
- Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures**. This does not apply to an Insured Person participating in a Clinical Trail as specifically stated in the sections of this Policy titled "Clinical Trials
- 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.**
- Any services required by state or federal law to be supplied by a public school system or school district.
- Any **services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- **If the Insured Person is eligible for Medicare** Part A, B or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.

- **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Professional **services or supplies received or purchased directly or on Your behalf by anyone, including a Physician, from** any of the following:
    - Yourself or Your employer;
    - a person who lives in the Insured Person's home, or that person's employer;
    - a person who is related to the Insured Person by blood, marriage or adoption, or that person's employer.
- **Custodial Care**.
- Inpatient or outpatient **services of a private duty nurse** except as specifically provided in this Policy.
- Inpatient room and board charges in connection with a **Hospital stay primarily for physical therapy or treatment of chronic pain**; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
- 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 received during an inpatient stay when the stay is primarily related to social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental, Emotional or Functional Nervous Disorders.
- 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. Services specifically listed as covered under "Short Term Rehabilitative Therapy" and "Habilitative Therapy" are not subject to this exclusion.

- 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.
- **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.
- 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.
- **Private duty nursing**, except as provided as part of the Home Health Care Services, Hospice Services, or Hospital benefits in this Policy.
- Inpatient room and board **charges in connection with a Hospital stay primarily for diagnostic tests** which could have been performed safely on an outpatient basis.
- **Dental services**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **Dental Implants**: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
- **Hearing aids** including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs) except as specifically stated in this Policy, limited to the least expensive professionally adequate device. A hearing aid is any device that amplifies sound.
- **Genetic screening** or preimplantations 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 except as specifically stated in this Policy.
- **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, or Preventive Care Services.
- An **eye surgery solely for the purpose of correcting refractive defects** of the eye, such as nearsightedness (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 birth abnormalities, deformity caused by Injury or congenital defects, 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 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 nonmedical ancillary services for learning disabilities and developmental delays.
- **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; music therapy; meditation; visualization; acupuncture; acupressure, reflexology, light therapy, aromatherapy, energy-balancing; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf.
- **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 do not consist exclusively of 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.
- 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 sterilization reversals and in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in the** "**Comprehensive Benefits: What the Policy Pays For" and "What's Covered", section in this Policy.**
- **Cryopreservation** of sperm or eggs or storage of sperm for artificial insemination (including donor fees).

- All **non-prescription Drugs**, devices and/or supplies, except insulin and drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription: **Injectable drugs** ("self-injectable medications) **that do not require Physician supervision;**; **All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision** and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, and **Self-administered Injectable Drugs**, except as 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.
- 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.
- Any **off label cancer drug** that has been prescribed for a specific type of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration (U.S. FDA) except as provided under Comprehensive Benefits.
- Fees associated with the **collection or donation of blood or blood products**, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration **for the purpose of general improvement in physical condition.**
- **Orthopedic shoes** (except when joined to braces), shoe inserts, foot orthodic devices except as required by law for diabetic patients.
- Services primarily for **weight reduction or treatment of obesity including morbid obesity**, or any care which involves weight reduction as a main method for treatment, except as otherwise stated in the Policy.
- **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.
- Massage therapy.
- **Educational services except educational services specifically required under Patient Protection and Affordable Care Act (PPACA) or and as specifically provided or arranged by Cigna.**

- **Nutritional counseling or food supplements** except as stated in this Policy.
- **Exercise equipment, comfort items and other medical supplies and equipment** including, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and Consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this Policy.
- **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and under 'Physical and/or Occupational Therapy/Medicine' in the section of this Policy titled "Comprehensive Benefits "What the Policy Pays For".
- All **Foreign Country Provider charges** are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive, "Benefits What the Policy Pays For".
- **Growth Hormone Treatment** except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition.
- **Routine foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet, except as otherwise stated in this Policy.
- **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the **services of a standby Physician**.
- Charges for **animal to human organ transplants**.
- **Claims received by Cigna after 15 months from the date service was rendered**, except in the event of a legal incapacity.

Prescription Drug Benefits

Pharmacy Payments

For Definitions associated with Prescription Drug benefits, refer to the 'Definitions' section of this Policy.

Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the annual medical Deductible and, once the Deductible is satisfied, subject to any applicable Copays and/or Coinsurance shown in the Benefit Schedule.

Cigna's Prescription Drug List is available upon request by calling the Customer Service number on Your ID card or on www.mycigna.com.

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

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

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

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

If You redeem a coupon or offer from a pharmaceutical manufacturer for a drug covered under this Policy, Cigna may not allow the dollar amount of the coupon or offer to reduce Your Annual Deductible, Copayment and/or Coinsurance. Cigna has the right to determine the amount and duration of any reduction, coupon or financial incentive available for any specific drug covered under this Policy.

Prescription Drugs and Specialty Medication Covered as Medical

When Prescription Drugs and Specialty Medications on Cigna's Prescription Drug List are administered in a healthcare setting by a Physician or health care professional, and are billed with the office or facility charges, they will be covered under the medical benefits of this Policy. However, they may still be subject to Prescription Drug Prior Authorization or Step Therapy requirements.

Covered Expenses

If the Insured Person(s), while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Benefit Schedule. When the Insured Person(s) is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Benefit Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to You or Your Family Members by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When You or Your family Members are issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

What Is Covered

- Outpatient Drugs and medications that Federal and/or applicable State law restrict to sale by Prescription only, except insulin which does not require a prescription.
- Pharmaceuticals to aid smoking cessation in accordance with “A” or “B” recommendations of the U.S. Preventive Services Task Force.
- Insulin (no prescription required) syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.
- Self-Administered Injectable Drugs, and syringes for the self-administration of those Drugs.
- Orally administered anti-cancer medications prescribed in connection with cancer chemotherapy treatments.
- All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.
- Contraceptive Drugs and devices approved by the FDA.
- Specialty Medications are covered

Conditions of Service

The Drug or medicine must be:

- Prescribed in writing except for insulin, by a Physician and dispensed within one year of being prescribed, subject to Federal or state laws.
- Approved for use by the Food and Drug Administration.
- For the direct care and treatment of the Insured Person's Illness, Injury or condition; however dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Physician for the care and treatment of an Insured Person’s illness.
- Purchased from a licensed retail Pharmacy or ordered by mail through the mail order pharmacy program.

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

Exclusions

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

- Drugs not approved by the Food and Drug Administration:
- 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 infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs are covered under 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;
- Implantable contraceptive products inserted by the Physician are covered under the Plan's medical benefits;
- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies; except for those pertaining to Diabetic Supplies and Equipment;

- Prescription vitamins (other than prenatal vitamins), dietary supplements, herbal supplements, and fluoride other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);
- Drugs used for cosmetic purposes that have no medically acceptable use, such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
- Injectable or Infused immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or Fractions are covered under the medical benefits of this Policy;
- Medications used for travel prophylaxis, except anti-malarial drugs;
- Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured's Person's condition; Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Drugs obtained outside the United States;
- Any fill or refill of Prescription Drugs and Related Supplies that is to replace those lost, stolen, spilled, spoiled or damaged before the next refill date;
- 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.

Limitations

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

- Up to a 90-day supply, at a retail Pharmacy for Preferred Generic, Non-Preferred Generic, Preferred Brand, Non-Preferred Brand and Up to a 30-day supply of Specialty medications, unless limited by the drug manufacturer's packaging: or
- Up to a 90-day supply at a mail-order Pharmacy or Preferred Generic, Non-Preferred Generic, Preferred Brand, Non-Preferred Brand and Up to a 30-day supply of Specialty medications, unless limited by the drug manufacturer's packaging; or
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification.

- Managed drug limits (MDL) may apply to dose and/or number of days' supply of certain drugs; managed drug limits are based on recommendations of the federal Food and Drug Administration (FDA) and the drug manufacturer.
- To a dosage and/or dispensing limit as determined by the P&T Committee.

Prescription Drug Formulary Information

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

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

The Prescription Drug List is updated once a year as follows:

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

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

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

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

Changes to Prescription Drug Formulary:

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

Coverage of New Drugs

All new Food and Drug Administration (FDA)-approved drug products (or new FDA-approved indications) are designated as Non-Prescription Drug List drugs until the Cigna business decision team makes a placement decision on the new drug (or new indication), which decision shall be based in part on the P & T Committee's clinical review of the drug. The business decision team shall make reasonable efforts to make a placement decision for all new FDA-approved drugs (or new indications) within 180 days of the product's release onto the market. Prescription Drug Lists (formularies) are created in conjunction by the P&T Committee and Cigna business decision team.

Prescription Drug List Exception and Prior Authorization Process

Prior Authorization or Step Therapy is required for certain Prescription Drugs and Related Supplies. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a Step Therapy determination. Step Therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If Your Physician believes 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.

Reimbursement/Filing a Claim

When an Insured Person purchases Prescription Drugs or Related Supplies through a retail Participating Pharmacy they pay any applicable Copay, Coinsurance or Deductible shown in the Schedule at the time of purchase. The Insured Person does not need to file a claim form.

If an Insured Person(s) purchases the Prescription Drugs or Related Supplies through a non-Participating Pharmacy, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed.

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

Claims and Customer Service

Drug claim forms are available upon written request to:

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

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

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

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

Pediatric Vision Services Performed by an Ophthalmologist or Optometrist

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

Definitions:

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

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

Pediatric Vision Benefits

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

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

What's Covered

Covered Benefits for Insured Person, through the end of the month in which the Insured Person turns 19 years of age:

- Examinations – One vision and eye health evaluation per year by an Optometrist or an Ophthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.
- Eyeglass lenses include all prescription including prism, choice of polycarbonate, glass or plastic standard single vision, lined bifocal, lined trifocal, lenticular and standard progressive lenses: including these additional lens add-ons:
  - Polycarbonate lenses;
  - Ultra-Violet (UV) coating;
  - Scratch-coating;
  - Oversize lenses;
  - All Solid and gradient tints;
  - Photochromic Glass or Plastic (i.e. Transitions)
  - Minimum 20% savings* on all additional lens enhancements you choose for your lenses, including but not limited to: anti-reflective coatings; photochromic (glass or plastic); polarized, Hi-Index and lens styles such as Blended Segment, Intermediate, and Premium Progressive lenses.

    * Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

- Frames – One frame for prescription lenses per year from Pediatric Frame Collection. Only frames in the Pediatric Frame Collection are covered at 100%. Non-Collection Frames: the Insured Persons cost share is up to 75% of retail.
- Elective Contact Lenses– One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year), including the professional services.
- Therapeutic Contact Lenses are covered for a one year supply, regardless of the contact lens type, including professional services, in lieu of frame and lenses. Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by Your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction are not covered.
- Low Vision Coverage: Supplemental professional low vision services and aids are covered in full once every 12 months for an Insured with partial sight, or whose sight is not fully correctable with surgery, pharmaceuticals, contact lenses or glasses. There are various low vision aids, such as the bioptic telescope, which can aid the Insured Person with their specific needs.
    - Some Cigna Vision Network Eye Care Professionals may not offer these services. Please check with your eye care professional first before scheduling an appointment.

Exclusions

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "What's Covered" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lens treatments, "add ons", or lens coatings not otherwise listed in "What's Covered." within this section.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- 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.

Cigna Vision Providers

To find a Cigna Vision Provider, or to get a claim form, the Insured Person should visit **www.mycigna.com** and use the link on the vision coverage page, or they may call Member Services using the toll-free number on their identification card.

Reimbursement/Filing a Claim

When an Insured Person(s) has an exam or purchases Materials from a Cigna Vision Provider they pay any applicable Copayment, Coinsurance or Deductible shown in the Schedule at the time of purchase. The Insured Person does not need to file a claim form.

If an Insured Person(s) has their exam or purchases Materials from a provider who is not a Cigna Vision Provider, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed. Send a completed Cigna Vision claim form and itemized receipt to:

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

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

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

General Provisions

Alternate Cost Containment Provision

We may, in certain situations, approve services under an alternate treatment plan. An alternate treatment plan may include services or supplies otherwise limited or excluded by the Policy. The alternate treatment plan must be mutually agreed to by Us, the Insured Person, and the Physician, Provider, or other healthcare practitioner. Our offering an alternate treatment plan in a particular case in no way commits Us to do so in another case, nor does it prevent Us from strictly applying the express benefits, limitations, and exclusions of the Policy at any other time or for the Insured Person.

Insurance with Other Insurers

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

MEDICARE ELIGIBLES

Cigna will pay as the Secondary Plan for an Insured Person who is eligible for Medicare as permitted by the Social Security Act of 1965 as amended.

Cigna will estimate the amount Medicare would have paid, and pay as secondary to that estimated amount in the following circumstances:

- An Insured Person who is eligible to enroll in Part B of Medicare but is not enrolled.

An Insured Person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for that person.

WHEN YOU HAVE A COMPLIANT OR AN APPEAL

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, 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 appeals procedure. 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. The Appeals Process Information Packet ("Appeal Packet") describes the process by which Members may obtain information and submit concerns regarding service, benefits, and coverage. For more information, see the Appeals Process Information Packet ("Appeal Packet"). We will provide you a copy of the Appeal Packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call Customer Services at the toll-free number that appears on your Benefit Identification card.

Appeals Procedure

To initiate an appeal, the Insured Person must submit a request for an appeal by calling or writing within two years of receipt of a denial notice. They can call the Customer Service Toll-Free number that appears on the Benefit Identification Card, explanation of benefits or claim form, or write to the following address:

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

They should state the reason why they feel the appeal should be approved and include any information supporting the appeal. If the Insured Person is unable or chooses not to write, they may ask to register the appeal by telephone. They may call us at the toll-free number or address on their Benefit Identification card, explanation of benefits or claim form.

If the appeal involves a coverage decision based on issues of medical necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. For all other coverage plan-related appeals, a review will be conducted by someone who was a) not involved in any previous decision related to your appeal, and b) not a subordinate of previous decision makers. Provide all relevant documentation with your appeal request.

Cigna will acknowledge in writing that we have received the Insured Person's request within five (5) working days after receiving the request. For required pre-service and concurrent care coverage determinations, Cigna's review will be completed within fifteen (15) calendar days. For post-service claims, Cigna's review and written notification of the decision will be completed within thirty (30) calendar days. If more time or information is needed to make the pre-service or concurrent care determination, Cigna will notify the Insured Person in writing to request an extension of up to fifteen (15) calendar days and to specify any additional information needed by us to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to the Insured Person as soon as possible and sufficiently in advance of the decision, so that the Insured Person will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, CG will provide the rationale to the Insured Person as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

The Insured Person may request that the appeal process be expedited if, their Primary Care Physician or treating Physician certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in the Insured's medical condition which cannot be managed without the requested services, or the appeal involves non-authorization of an admission or continuing inpatient Hospital stay.

If the Insured Person requests that their appeal be expedited because the time frames under this process would seriously jeopardize their life, health or ability to regain maximum function or in the opinion of their PCP or treating Physician would cause them severe pain which cannot be managed without the requested services, the Insured Person may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to the Insured Person's medical condition.

When an appeal is expedited, Cigna will respond orally with a decision within seventy-two (72) hours, followed up in writing.

At any time during the appeal process Cigna has the option to send the Insured Person's appeal directly to External Independent Review without making a decision during the appeal process.

External Independent Review

1. Eligibility

Under Arizona law, an Insured Person may seek an Expedited or Standard External Independent Review only after seeking any available expedited or standard internal Appeal. The Insured Person's request for an Expedited or Standard External Independent Review should be submitted in writing.

2. Deadlines Applicable to the Standard External Independent Review Process

After receiving written notice from Cigna that the Insured Person's Appeal has been denied, the Insured Person has four (4) months to submit a written request to Cigna for External Independent Review. The request must include any material justification or documentation to support the request for the service or payment of a claim.

a. Medical Necessity Issues

These are cases where Cigna has decided not to authorize a service because Cigna thinks the services the Insured Person (or Your treating Provider) are asking for, are not medically necessary to treat their problem. For medical necessity cases, the independent reviewer is a Provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a Provider who typically manages the condition under review. If the Insured's appeal for External Independent Review involves an issue of medical necessity:

(1) Within five (5) working days of receipt of the request for External Independent Review, Cigna will:

- mail a written notice to the Insured Person, their PCP or treating Provider, and the Director of the Arizona Department of Insurance ("Director of Insurance") of the Insured Person's request for External Independent Review, and
- Send the Director of Insurance: the request for review; the Insured Person 's medical records and supporting documentation used to render the decision; a summary of the applicable issues including a statement of the decision; the criteria used and clinical reasons for the decision; and the relevant portions of Cigna's utilization review guidelines. Cigna must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

(2) Within five (5) days of receiving our information, the Insurance Director must send all submitted information to an external independent review organization (the "IRO").

(3) Within twenty-one (21) days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

(4) Within five working days of receiving the IRO's decision, The Insurance Director must mail a notice of the decision to Cigna, the Insured Person and the treating Provider. If the IRO decides that Cigna should provide the service or pay the claim, Cigna must then authorize the service or pay the claim. If the IRO agrees with Cigna's decision to deny the service or payment, the appeal is over. The Insured Person's only further option is to pursue Your claim in Superior Court.

b. Coverage Issues

These are cases where Cigna has denied coverage because Cigna believes the requested service is not covered under the Policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer. If the Insured Person's appeal for External Independent Review involves an issue of service of benefits coverage or a denied claim:

(1) Within five (5) working days of receipt of the Insured Person 's request for External Independent Review, Cigna will:

- mail a written notice to the Insured, their PCP or treating Provider, and the Director of Insurance of the request for External Independent Review, and

- send the Director of Insurance: the Insured Person's request for review; the, all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

(2) Within fifteen (15) working days of the Director's receipt of the Insured's request for External Independent Review from Cigna, the Director of Insurance will:

- determine whether the service or claim is covered, and
- mail the decision to Cigna. If the Director decides that Cigna should provide the service or pay the claim, Cigna must do so.

(3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward the Insured Person's case to an IRO. The IRO will have twenty-one (21) days to make a decision and send it to the Insurance Director. The Insurance Director will have five working days after receiving the IRO's decision to send the decision to Cigna, the Insured Person, and the treating provider.

(4) Cigna will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director of Insurance regardless of whether Cigna elects to seek judicial review of the decision made through the External Independent Review Process.

(5) If the Insured Person disagrees with the Insurance Director's final decision on a contract coverage issue, they may request a hearing with the Office of Administrative Hearings ("OAH"). If Cigna disagrees with the Insurance Director's final decision, Cigna may also request a hearing before the OAH. A hearing must be requested within thirty (30) calendar days of receiving the Insurance Director's decision.

3. Deadlines Applicable to the Expedited External Independent Review Process

After the Insured Person receives written notice from Cigna that their Expedited Appeal has been denied, the Insured has only five (5) business days to submit a written request to Cigna for an Expedited External Independent Review. The request must include any material justification or documentation to support the request for the service or payment of a claim.

a. Medical Necessity Issues

If the appeal for Expedited External Independent Review involves an issue of medical necessity:

(1) Within one (1) working day of receipt of the Insured Person 's request for an Expedited External Independent Review, Cigna will:

- mail a written acknowledgment to You, Your PCP or treating Provider, and the Director of the request for Expedited External Independent Review, and

- forward to the Director the request for Expedited External Independent Review, the terms of the agreement in the contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of Cigna's decision, the criteria used and the clinical reasons for the decision, relevant portions of Cigna's utilization review policy and the name and the credentials of the licensed health care provider who reviewed the case.

(2) Within two (2) working days after the Director receives the information outlined above, the Director will choose an independent review organization (IRO) and forward to the organization all of the information received by the Director.

(3) Within five (5) working days of receiving a case for Expedited External Independent Review from the Director, the IRO will evaluate and analyze the case and based on all the information received, render a decision and send the decision to the Director. Within one (1) working day after receiving a notice of the decision from the IRO, the Director will mail a notice of the decision to the Insured Person, their PCP or treating provider, and Cigna.

b. Coverage Issues

If the Insured Person‘s appeal for Expedited External Independent Review involves a contract coverage issue:

(1) Within one (1) working day of receipt of the request for an Expedited External Independent Review, Cigna will:

- mail a written acknowledgment to the Insured Person, their PCP or treating Provider, and the Director of the Insured Person’s request for Expedited External Independent Review, and
- forward to the Director the Insured Person’s request for an Expedited External Independent Review, the terms of the agreement in Your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of Cigna's decision, the criteria used and the clinical reasons for the decision, relevant portions of Cigna's utilization review policy and the name and the credentials of the licensed health care provider who reviewed the case.

(2) Within two (2) working days after receipt of all the information outlined above, the Director will determine if the service or claim is covered and mail a notice of the determination to the Insured Person, their PCP or treating provider, and Cigna.

(3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward the case to an IRO. The IRO will have five working days to make a decision and send it to the Director. The Director will have one working day after receiving the IRO's decision to send the decision to Cigna, the Insured Person and the treating provider.

(4) Cigna will provide any Covered Service or pay any covered claim determined to be Medically Necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director regardless of whether Cigna elects to seek judicial review of the decision made through the External Independent Review Process.

(5) If the Insured disagrees with the Insurance Director's final decision on a contract coverage issue, the Insured may request a hearing with the Office of Administrative Hearings ("OAH"). If Cigna disagrees with the Director's final decision, Cigna may also request a hearing before OAH. A hearing must be requested within thirty (30) days of receiving the Director's decision.

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

Under Arizona law, if the Insured intends to file suit regarding a denial of benefit claim or services the Insured Person believes are Medically Necessary, the Insured Person is required to provide written notice to Cigna at least thirty (30) days before filing the suit stating their intention to file suit and the basis of their suit. The Insured Person must include in their notice the following:

Member Name
Member Identification Number
Member Date of Birth
Basis of Suit (reasons, facts, date(s) of treatment or request)

Notice will be considered provided by the Insured Person on the date received by Cigna. The notice of intent to file suit must be sent to Cigna via Certified Mail Return Receipt Request to the following address:

Attention: HealthCare Litigation Unit W-26
Notice of Intent to File Suit
Cigna Health and Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written documents required to be mailed during the process is deemed received by the person to whom the document is properly addressed on the fifth (5^{th}) working day after being mailed. "Properly addressed" means the Insured's last known address.

Complaints to the Arizona Department of Insurance

The Director of the Arizona Department of Insurance is required by law to require any Insured Person who files a complaint with the Arizona Department of Insurance relating to an adverse decision to first pursue the review process established by the Arizona Legislature and Cigna as described above.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Policy provisions on which the determination is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and (6) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

Legal Action

In most instances, the Insured Person may not initiate a legal action against Cigna until the Insured Person has completed the Appeal processes.

Binding Arbitration

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

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

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

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

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

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two (2) years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

Class Action Waiver: Without limiting Your rights under A.R.S. § 20-3152(D) or A.R.S. § 20-3153, You (including any legal representative acting on Your behalf) hereby expressly waive under this provision of this Policy, You (including any legal representative acting on Your behalf) expressly waive the right to participate, as a plaintiff or class member, in any purported class, collective, representative, multiple plaintiff or similar proceeding ("Class Action"). Under this provision of the Policy You expressly waive the ability to maintain a Class Action in any forum. In the case of an arbitration, the Arbitrator shall not have authority to conduct a Class Action, combine or aggregate similar claims of an entity or person not a party to this agreement, or make an award to any person or entity not a party to this agreement.

Statements Not Warranties
All statements and descriptions in any application for insurance or in negotiations therefore, by or in behalf of the insured Person, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under the Policy unless:

1. Fraudulent.
2. Material either to the acceptance of the risk, or to the hazard assumed by the insurer.
3. The insurer in good faith would either not have issued the Policy, or would not have issued a Policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the Policy or otherwise.

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

Cancellation:
We may cancel this Policy for any of the reasons enumerated below by written notice delivered to You or mailed to Your last address as shown by Our records, stating when, not less than thirty days thereafter, such cancellation shall be effective; and after the Policy has been continued beyond its original term You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, We will return promptly the unearned portion of any premium paid. If the You cancel, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where You resided when the Policy was issued. If We cancel, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

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

1. If You did not purchase Your Plan from the Marketplace, and You fail to pay Your premiums as they become due or by the end of the 31 day of the grace period.
2. If You did purchase Your Plan from the Marketplace, and You elected to receive the advanced premium tax credit and have previously paid premium for at least one month during the current Policy Year. You have a grace period of 3 months. During the first month of the grace period Cigna will pay all appropriate claim expenses submitted. However, during the second and third month Cigna will pend Your claims, and if You fail to pay the full premium due by the end of the third month, Cigna will deny the pending claims.
3. When You cease to meet the eligibility requirements in the “Who is Eligible for Coverage?” section of this Policy.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, In this event, Arizona 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 Arizona, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. 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.

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.

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

Modification of Coverage: We reserve the right to modify this policy, including Policy provisions, benefits and coverage's, so long as such modification, including rate modification, is consistent with state or federal law and effective on a uniform basis among all individuals with coverage under this same Policy form. We will only modify this Policy for all Insured Persons in the same class and covered under the same Policy form, and not just on an individual basis. We will send written notice 60 days in advance, and the change will become effective on the date shown in the notice or on the next scheduled premium due date thereafter. Payment of the premiums will indicate acceptance of the change. This Individual Plan is renewable annually, payment of the premiums will indicate acceptance of the change.

Renewal: This Policy renews on a Calendar Year basis.

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

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

The Insured Person(s) are the only persons entitled to receive benefits under this Policy. FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF THIS POLICY AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.

The Effective Date of this Policy is printed on the Cigna identification card and on the Policy specifications page.

Cigna is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care in any Hospital, Free-Standing Outpatient Surgical Facility, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.

Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed on our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

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

When the amount paid by Cigna exceeds the amount for which We are liable under this Policy, We have the right to recover the excess amount from the Insured Person unless prohibited by law.

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

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

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

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

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

If Insured Person(s) were **covered by a prior Individual Cigna Policy** that is replaced by this Policy with no lapse of coverage:

- Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer

If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

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

Changing Primary Care Physicians:

The Insured Person may request a transfer from one Primary Care Physician to another by contacting us at the member services number on ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, The Insured Person will be notified for the purpose of selecting a new Primary Care Physician, if they choose.

How to File a Claim for Benefits

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

Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at

Medical Claims
P. O. Box 188061
Chattanooga, TN 37422-8061

or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer

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

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made

Claim Reminders:

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

Proof of Loss: You must give Us written proof of loss within 15 months after the date of the loss, except in absence of legal incapacity. Proof of loss is a claim form or letter as described above. Canceled checks or receipts are not acceptable. Cigna will not be liable for benefits if it does not receive written proof of loss within this time period.

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

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

We will recognize and consider any assignment made under the Policy, only if:
1. It is duly executed on a form acceptable to Us; and
2. a copy is on file with Us; and
3. it is made by a Provider licensed and practicing within the United States.

We may, at Our option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Dependent, You or Your Dependents are responsible for reimbursing the provider and Our payment to You will be considered fulfillment of Our obligation.

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

Time Payment of Claims: All claims and indemnities payable under the terms of this Policy shall be paid immediately following receipt by Us of due proof of loss. The Insured or an Insured's assignee shall be notified by Us of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim.

Claim Determination Procedures Under Federal Law (provisions of the laws of Arizona may supersede)

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the Policy. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below.

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice medical necessity determination." The Policy describes who is responsible for obtaining this review. The Insured Person or their authorized representative (typically, their health care provider) must request Medical Necessity determinations according to the procedures described below, in the Policy, and in the Insured Person's provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, the Insured Person or their representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Policy, in the Insured Person's provider's network participation documents, and in the determination notices.

Pre-service Medical Necessity Determinations

When the Insured Person or their representative requests a required Medical Necessity determination prior to care, Cigna will notify the Insured Person or their representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify the Insured Person or their representative within 15 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date the Insured Person or their representative responds to the notice.

If the determination periods above would (a) seriously jeopardize the Insured Person's life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Insured Person's health condition, cause them severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's Physician reviewer will defer to the determination of the treating Physician regarding whether an expedited determination is necessary. Cigna will notify the Insured Person or their representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify the Insured Person or their representative within 24 hours after receiving the request to specify what information is needed. The Insured person or their representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify the Insured Person or their representative of the expedited benefit determination within 48 hours after the Insured Person or their representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If the Insured Person or their representative fails to follow Cigna's procedures for requesting a required preservice medical necessity determination, Cigna will notify them of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the Insured Person or their representative requests written notification.

Concurrent Medical Necessity Determinations

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

Post-service Medical Necessity Determinations

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

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

Post-service Claim Determinations

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

Notice of Adverse Determination

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

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

Premiums

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

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)

b. A change in age of any 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 once per Policy Year on 60 days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Insured Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown in 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.