Cigna Health and Life Insurance Company ("Cigna")
Cigna Connect Flex Silver 2500 Plan
Native American/Alaskan Native Over 300% Plan

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

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

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

Remember, services from Out-of-Network providers are not covered except for initial care to treat and stabilize an emergency medical condition. For additional details see the "How The Plan Works" section of Your Policy.

MEDICAL BENEFIT SCHEDULE

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible and any additional deductible(s) unless specifically waived	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY:
Medical Benefits	
Annual Plan Deductible *Individual* *Family*	**Deductible** $2,500 $5,000
Out-of-Pocket Maximum *Individual* *Family*	**Out-of-Pocket Maximum** $7,150 $14,300 The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties and Policy Maximums.
Coinsurance	You and Your Family Members pay 40% of Charges after any Policy Deductible.

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible and any additional deductible(s) unless specifically waived	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY:
Prior Authorization Program **Prior Authorization – Inpatient Services**	**Your Participating Provider must obtain approval** for inpatient admissions. Services without required referral or authorization are Not Covered.
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 Participating Provider must obtain approval** for certain outpatient procedures and services. Services without required referral or authorization are Not Covered.
All Preventive Well Care Services Please refer to " Benefits/Coverage (What is Covered)" section of this Policy for additional details	0%, Deductible waived
Pediatric Vision Care Performed by an Ophthalmologist or Optometrist for Insured Persons less than 19 years of age. ***Please be aware that the Pediatric Vision network is different from the network for Your medical benefits**	
Comprehensive Eye Exam and Refraction for Children Limited to one exam per year	0%, Deductible waived
Pediatric Frames for Children Limited to one pair per 2 years	0%, Deductible waived
Eyeglass Lenses for Children Limited to one pair per 2 years	0%, Deductible waived
Single Vision, Lined Bifocal, Lined Trifocal, Lenticular and frames	0%, Deductible waived
Contact Lenses and Professional Services for Children (Limited to one pair per 2 years)	
Elective	
Therapeutic	
Note: Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit.	

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible and any additional deductible(s) unless specifically waived	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY:
Physician Services **Office Visit or House Call** (does not include allergy testing and treatment/injections lab and x-ray tests and surgery done in the office) (for these services see Physician Services continued)	
Primary Care Physician (PCP)	$10 Copayment per office visit, Deductible waived
Specialist Physician (including consultant, referral and second opinion services)	40%
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.	
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.	Primary Care Physician (PCP) Office Visit benefit applies
Physician Services, continued	
Surgery in Physician's office	40%
Outpatient Professional Fees for Surgery	40%
Inpatient Surgery, Anesthesia, Radiation Therapy	40%
In-hospital visits	40%
Allergy testing and treatment/injections	40%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible and any additional deductible(s) unless specifically waived	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY:
Indian Health Program / Tribal Health Program Services Any Covered Services provided by an Indian Health Program or Tribal Health Program Note: these benefits apply only to an Insured Person who is either a member of a federally-recognized Native American tribe or an Alaska native.	0%
Hospital Services Inpatient Hospital Services Emergency Admissions	40% Refer to the Emergency Services Benefit Schedule for benefits on specific services.
Inpatient treatment in a multidisciplinary rehabilitation program Maximum of 60 days per condition per calendar year	40%
Women's Contraceptive Services, Family Planning and Sterilization	0%, Deductible waived
Male Sterilization	40%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible and any additional deductible(s) unless specifically waived	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY:
Maternity (Pregnancy and Delivery)/Complications of Pregnancy	
Initial visit to confirm Pregnancy	
Primary Care Physician (PCP)	$10 Copayment per office visit, Deductible waived
Specialist Physician	40%
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.	
All subsequent Prenatal visits, Postnatal visits and Physician's delivery charges (i.e., global maternity fee)	40%
Physician's Office Visits in addition to the global maternity fee	
Primary Care Physician (PCP)	$10 Copayment per office visit, Deductible waived
Specialist Physician	40%
Delivery – Facility (Inpatient Hospital, Birthing Center)	40%
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	40%
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans and Nuclear Medicine) Facility and interpretation charges	40%
All Other Laboratory and Radiology Services Facility and interpretation charges	
Physician's Office	40%
Free-standing/independent lab or x-ray facility	40%
Outpatient hospital lab or x-ray	40%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible and any additional deductible(s) unless specifically waived	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY:
Short Term Rehabilitative Services **Physical, Occupational, Speech Therapy** Maximum of 20 visits for each therapy per Insured Person, per calendar year **Note: Maximum does not apply to services for treatment of Autism Spectrum Disorders**	40%
Rehabilitative therapies for Insured Persons with congenital defects and birth abnormalities **Physical, occupational and speech therapy** Maximum of 20 visits for each therapy per Insured Person, per calendar year.	40%
Habilitative Services Maximum of 20 visits for each therapy, per Insured Person, per calendar year.	40%
Hearing Services Hearing exams and testing Hearing services and supplies Hearing aids (limit of 1 pair per child up to 18 years of age every 3 Years)	40%
Dental Care (other than Pediatric) Treatment for accidental injury to natural teeth, within 6 months of the accidental injury Anesthesia for dental procedures	40% 40%
Cardiac & Pulmonary Rehabilitation	40%
Chiropractic Services Maximum of 20 visits per Insured Person, per Calendar Year	40%
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	40%
Medical Foods to treat inherited metabolic disorders	40%
Amino Acid Based formula to treat Eosinophilic Gastrointestinal Disorder	40%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible and any additional deductible(s) unless specifically waived	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY:
Autism Spectrum Disorders (see "**Benefits/Coverage (What is Covered)**" section for specific information about what services are covered)	40%
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 100 days per Insured Person, per calendar year, combined for all facilities listed.	40%
Home Health Services Maximum of 28 hours per week	40%
Durable Medical Equipment	40%
Orthotic Devices	40%
Breast Feeding Equipment and Supplies **Note:** **Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.**	0%, Deductible waived
External Prosthetic Devices	20%, Deductible waived
Orthopedic Appliances	40%
Hospice Routine Home Care Inpatient Outpatient	 40% 40% 40%
Dialysis Inpatient Outpatient	 Inpatient Hospital Services benefit applies 40%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible and any additional deductible(s) unless specifically waived	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY:
Mental, Emotional or Functional Nervous Disorders (including Biologically Based Mental Illnesses or Disorders) & Substance Use Disorder Inpatient (includes Acute and Residential Treatment) Outpatient (includes individual, group, intensive outpatient and partial hospitalization) Office Visit All other outpatient services	 40% 40% 40%
Smoking Cessation **Medical treatment** (Prescription Drugs for smoking cessation treatment are covered under the Prescription Drug benefit)	40%
Organ and Tissue Transplants- (see benefit detail in "**Benefits/Coverage (What is Covered)"**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	 0% 40% 40%
Infertility **(see "Benefits/Coverage (What is Covered)" section for specific information about what services are covered and benefit limits which may apply)** **Inpatient** **Outpatient**	 Inpatient Hospital Services benefit applies 40%
Bariatric Surgery (Subject to medical necessity) **Inpatient** **Outpatient**	 Inpatient Hospital Services benefit applies 40%
Infusion and Injectable Special Prescription Medications **and related services or supplies administered by a medical professional in an office or outpatient facility.**	40%

EMERGENCY SERVICES BENEFIT SCHEDULE

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible and any additional deductible(s) unless specifically waived	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY:	OUT-OF-NETWORK PROVIDER (Based on the Maximum Reimbursable Amount) YOU PAY:
Emergency Services Benefits **Note: This Plan covers Emergency Services from In- and Out-of-Network Providers as shown:**		
Emergency Services – Hospital Emergency Room	40%	In-network benefit level for an Emergency Medical Condition only, otherwise Not Covered
Urgent Care Services	$75 Copayment per visit, Deductible waived	In-network benefit level for an Emergency Medical Condition only, otherwise Not Covered
Ambulance Services (Emergency transportation if the condition requires the use of medical services that only a licensed ambulance can provide.)		
Emergency Transport	40% for Ground or Air transport	In-network benefit level for an Emergency Medical Condition only, otherwise Not Covered
Non-Emergency Transport	Not Covered	Not Covered
Inpatient Hospital Services (for emergency admission to an acute care Hospital) Hospital Facility Charges	40%	In-Network benefit level until transferable to an In-Network Hospital, if not transferred then Not Covered
Professional Services	40%	In-Network benefit level until transferable to an In-Network Hospital, if not transferred then Not Covered

PRESCRIPTION DRUG BENEFIT SCHEDULE

BENEFIT INFORMATION	RETAIL PHARMACY YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
	AMOUNTS SHOWN BELOW ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
In the event that You request a Brand Name drug that has a Generic equivalent, You will be financially responsible for the amount by which the cost of the Brand Name drug exceeds the cost of the Generic drug plus the Generic Copay or Coinsurance indicated in the Benefit Schedule		
Prescription Drug Deductible	Integrated Medical and Prescription Drug Deductible	
	Cigna Retail Pharmacy Drug Program YOU PAY PER PRESCRIPTION OR REFILL:	**Cigna Mail Order Pharmacy Drug Program** YOU PAY PER PRESCRIPTION OR REFILL:
Tier 1: Preferred Generic	$8 Copayment, Deductible waived per Prescription or refill (Up to a 90 day maximum supply For Copay Plans, You pay a Copay for each 30 day supply.)	$20 Copayment, Deductible waived per Prescription or refill (Up to a 90 day maximum supply)
Tier 2: Non-Preferred Generic	$30 Copayment, Deductible waived per Prescription or refill (Up to a 90 day maximum supply For Copay Plans, You pay a Copay for each 30 day supply.)	$75 Copayment, Deductible waived per Prescription or refill (Up to a 90 day maximum supply)
Tier 3: Preferred Brand	$60 Copayment, Deductible waived per Prescription or refill (Up to a 90 day maximum supply For Copay Plans, You pay a Copay for each 30 day supply.)	$150 Copayment, Deductible waived per Prescription or refill (Up to a 90 day maximum supply)
Tier 4: Non-Preferred Brand	50% per Prescription or refill (Up to a 90 day maximum supply)	50% per Prescription or refill (Up to a 90 day maximum supply)
Tier 5: Specialty generic and brand name medications that meet criteria of specialty drugs	40% per Prescription or refill (Up to a 30 day maximum supply)	30% per Prescription or refill (Up to a 30 day maximum supply)
Preventive Drugs regardless of Tier Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including women's contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative	0%, Deductible waived per Prescription or refill (Up to a 90 day maximum supply)	0%, Deductible waived per Prescription or refill (Up to a 90 day maximum supply)

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

Cigna Health and Life Insurance Company ("Cigna")
Cigna Connect Flex Silver 2500
Native American/Alaskan Native Over 300% Plan

If You Wish To Cancel Or If You Have Questions

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

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

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

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

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

Guaranteed Renewable

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

Signed for Cigna by:

Matthew G. Manders, President

Anna Krishtul, Corporate Secretary

CONTACT US

You can contact Cigna at the phone number shown on your ID card, or at 1-800-Cigna24.

You can also contact Cigna at:

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

You can also get information at www.mycigna.com, including:

- Find participating providers in Your area
- View balances for Your Deductible and Out-of-Pocket Maximums
- Print an ID card
- View Your claim history

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

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

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ELIGIBILITY

Eligibility Requirements

This Policy is for residents of the state of Colorado. 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, at the time of application:

- You are a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and are reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought; and
- You are a resident of the state of CO; 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
- You do not reside in an Institution; 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, including a partner in a civil union who lives in the Service Area.
- Your children who live in the Service Area and have not yet reached age 26.
- Your stepchildren who live in the Service Area and have not yet reached age 26.
- Your own, or Your spouse's children, regardless of age, , who live in the Service Area and are dependent upon the Insured for support and maintenance due to a medically certified, continuing intellectual or physical disability. Cigna requires written proof of such disability and dependency. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's Newborn children are automatically covered for the first 31 days of life. To continue coverage past that time You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date of birth, and pay any additional premium. Coverage for a newborn dependent child enrolled within 61 days of birth will be retroactive to the date of the child's birth.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of adoption or initiation of a suit of adoption. To continue coverage past that time You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date of adoption, and pay any additional premium. Coverage for an adopted dependent child enrolled within 61 days of adoption will be retroactive to the date of the child's placement for adoption, initiation of a suit of adoption or after the date the child is placed with you for adoption, and paying any additional premium.
- A child who is placed with you for foster care, is automatically covered for 31 days from the date of placement with you for foster care. 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 placement with you for foster care, and pay any additional premium. Coverage for a foster child enrolled within 61 days of being placed with you for foster care will be retroactive to the date of the child's initial placement with you in foster care and paying 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 paying any additional premium. Court-ordered coverage for a dependent child enrolled within 61 days of the court order will be retroactive to the date of the court order.

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 Annual Open Enrollment Period must wait until the next Annual 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 Annual 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, specified under federal and Colorado law, 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 Dependents, and We must receive that application during the Annual Open Enrollment Period.

Your coverage under this Policy will then become effective upon the earliest day allowable under federal rules for that Year's 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.

When You are notified or become aware of a triggering event that will occur in the future, you may apply for enrollment in a new health benefit plan during the sixty (60) calendar days prior to the effective date of the triggering event, with coverage beginning no earlier than the day the triggering event occurs to avoid a gap in coverage. You must be able to provide written documentation to support the effective date of the triggering event at the time of application.

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:

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual involuntarily loses existing creditable coverage for any reason other than fraud, misrepresentation or failure to pay a premium.
- An eligible individual, and any dependents, 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 gains a dependent or becomes a dependent by marriage, civil union, birth, adoption, placement for adoption , placement in foster care or by entering into a designated beneficiary agreement pursuant to Colorado law.
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or

- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- A parent or legal guardian dis-enrolling a dependent, or a dependent becoming ineligible for the Children's Basic Health Plan;
- An individual becoming ineligible under the Colorado Medical Assistance Act;
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of Us, a producer, or an officer, employee or agent of the state Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Marketplace or Colorado Commissioner of Insurance that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The Marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month (does not apply to "off-marketplace" Plans, i.e. You did not purchase Your plan on a state marketplace)
- An eligible individual or enrollee demonstrates to the Marketplace, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the Marketplace may provide.

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

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

- In the case of birth, adoption or placement for adoption, the effective date will be the date of birth, adoption or placement for adoption;
- In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, coverage is effective 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.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

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 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 61DAYS AFTER BIRTH), WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED 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 60 DAYS ADVANCE NOTICE AND WE WILL REFUND ALL PREMIUMS YOU PAID FOR YOUR POLICY LESS THE AMOUNT OF ANY CLAIMS PAID BY CIGNA. RESCISSION OF YOUR COVERAGE WILL RESULT IN DENIAL OF ALL PENDING CLAIMS AND, IF CLAIM PAYMENTS EXCEED TOTAL PREMIUMS PAID, THEN CLAIMS PREVIOUSLY PAID BY CIGNA WILL BE RETROACTIVELY DENIED, OBLIGATING YOU TO PAY THE PROVIDER IN FULL FOR SERVICES RENDERED AT THE PROVIDER'S REGULAR BILLED RATE, NOT AT THE CIGNA NEGOTIATED RATE.

CHOICE OF HOSPITAL AND PHYSICIAN: Nothing contained in this Policy restricts or interferes with an Insured Person's right to select the Hospital or Physician of their choice. However, non-emergency services from a Non-Participating Provider are not covered by this Plan.

THIS IS A NETWORK-ONLY PLAN

That means this Plan does not provide benefits for any services You receive from an Out-of-Network Provider except:

- Services for Stabilization and initial treatment of a Medical Emergency, or
- Medically Necessary services that are not available through an In-Network Provider

In-Network Providers include Physicians, Hospitals, and other health care facilities. Check the provider directory, available at www.mycigna.com, or call the number on Your ID card to determine if a Provider is In-Network.

Choosing a Primary Care Physician

When You enroll as an Insured Person, You must choose a Primary Care Physician (PCP). Each covered Family Member also must choose a PCP. If You do not select a PCP, we will assign one for You. If Your PCP ceases to be a Participating Physician, You will be able to choose a new PCP. You may voluntarily change Your PCP for other reasons but not more than once in any calendar month. We reserve the right to determine the number of times during a Plan Year that You will be allowed to change Your PCP. If You select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following Your selection. If You select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example, if You notify us on June 10, the change will be effective on July 1. If You notify us on June 15, the change will be effective on August 1.

Your choice of a PCP may affect the specialists and facilities from which You may receive services. Your choice of a specialist may be limited to specialists in Your PCP's medical group or network, including a Limited Network. Therefore, You may not have access to every specialist or Participating Provider in your Service Area. Before You select a PCP, you should check to see if that PCP is associated with the specialist or facility You prefer to use. If the Referral is not possible, You should ask the specialist or facility about which PCPs can make Referrals to them, and then verify the information with the PCP before making your selection.

Changing Primary Care Physicians

The Insured Person may request a transfer from one Primary Care Physician to another by contacting Us at the Customer Service 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, We will notify You 30 days in advance, for the purpose of selecting a new Primary Care Physician, if You choose.

If Your PCP Leaves the Network

If Your PCP or Network Specialist ceases to be a Participating Physician, We will notify You in writing of his or her impending termination at least 30 days in advance of the date the PCP leaves the network and provide assistance in selecting a new PCP or identifying a new Network Specialist to continue providing Covered Services. If You are receiving treatment from a Participating Provider at the time his or her Participating Provider agreement is terminated, for reasons other than medical incompetence or professional misconduct, You may be eligible for continued care with that Provider.

Referrals to Specialists

You must obtain a Referral from Your PCP before visiting any Provider other than Your PCP in order for the visit to be covered. The Referral authorizes the specific number of visits that You may make to a provider within a specified period of time. If You receive treatment from a Provider other than Your PCP without a Referral from Your PCP, the treatment is not covered and You will be responsible for paying 100% of the associated costs.

Exceptions to the Referral process:

If You are a female Insured Person, You may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in "Benefits/Coverage (What Is Covered)" without a Referral from Your PCP.

If Your plan covers Expanded Access Telehealth Service, You do not need a PCP referral for electronic visits with an Expanded Access Telehealth Physician.

If You are an Insured Person under age 19, You may visit a Network Dentist for Pediatric Dental Benefits or a Network Vision Provider for Pediatric Vision Benefits without a Referral from Your PCP.

You do not need a Referral from Your PCP for Emergency Services as defined in the “Definitions." In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or Your local emergency service, police or fire department for help. You do not need a Referral from Your PCP for Emergency Services, but You do need to call Your PCP as soon as possible for further assistance and advice on follow-up care.

In an emergency, You should seek immediate medical attention and then as soon as possible thereafter You need to call Your PCP for further assistance and advice on follow-up care.

In an Urgent Care situation a Referral is not required but You should, whenever possible, contact Your PCP for direction prior to receiving services.

You may also visit a qualified Participating Provider for covered Pediatric Vision Care Services and Pediatric Dental Care Services, as defined in “Covered Services and Supplies”, without a referral from Your PCP.

Standing Referral to Specialist

You may apply for a standing referral to a provider other than Your PCP when all of the following conditions apply:

1. You are enrolled for coverage under this Plan;
2. You have a disease or condition that is life threatening, degenerative, chronic or disabling;
3. Your PCP in conjunction with a Network Specialist determines that Your care requires another Provider’s expertise;
4. Your PCP determines that Your disease or condition will require ongoing medical care for an extended period of time;
5. The standing referral is made by Your PCP to a network specialist who will be responsible for providing and coordinating Your specialty care; and
6. The network specialist is authorized by Cigna to provide the services under the standing referral.

We may limit the number of visits and time period for which You may receive a standing referral. If You receive a standing referral or any other referral from Your PCP, that referral remains in effect even if the PCP ceases to be a Participating Physician. If the treating specialist leaves Cigna’s network or You cease to be an Insured Person, the standing referral expires.

Network Exception

If Medically Necessary Covered Services are not available through Participating Physicians or Participating Providers, Cigna will, upon the request of a Network PCP or Provider:

- Allow Referral to an Out-of-Network (Non-Participating) Provider; and
- Fully reimburse the Out-of-Network (Non-Participating) Provider at the Usual and Customary rate or at an agreed rate:

Prior to denying a request for referral to an Out-of-Network (Non-Participating) Provider, Cigna must provide for a review conducted by a Specialist of the same or similar type of specialty as the Physician or Provider to whom the Referral is requested.

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.

Note Regarding Health Savings Accounts

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

NOTICE: 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.**

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 facility MAY RESULT IN A PENALTY OR LACK OF COVERAGE FOR THE SERVICES PROVIDED. 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 OR LACK OF COVERAGE FOR THE SERVICES PROVIDED.

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

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

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

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

Retrospective Review

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

Prior Authorization—Prescription Drugs:

Certain Prescription Drugs also may require Prior Authorization by Cigna. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If the Physician 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, 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.

How the Plan 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. **Services for which You do not have a PCP Referral are not covered. Services performed by an Out-of-Network (Non-Participating) Provider are not covered under this Plan except for Emergency Services.** 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.

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before benefits are available. Deductibles apply to all Covered Expenses as described in the Definitions section of this Policy, unless expressly stated otherwise in the Benefit Schedule. Deductibles do not include any amounts in excess of Maximum Reimbursable Charges, Coinsurance, Prescription Drug Copays, Copayments, any penalties, or expenses incurred in addition to 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 received the service or supply.

Deductible

The 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 Deductible will apply. Each Insured Person can contribute up to the individual Deductible amount toward the Family Deductible. Once this Family Deductible is satisfied, no further Family Deductible is required for the remainder of that Year.

Out-of-Pocket Maximum

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 in a Calendar Year, the Insured Person will no longer have to pay any Coinsurance for Covered Expenses incurred during the remainder of that Year.
- If you cover other Family Member(s), each Insured Person's Covered Services accumulate toward the Family Out-of-Pocket Maximum. Once the Out-of-Pocket has been met, the Family will no longer have to pay any Coinsurance for Covered Expenses incurred during the remainder of that Year

Penalties

A Penalty is an amount of Covered Expenses that is:

- Not counted toward any Deductible;
- Not counted toward the Out-of-Pocket Maximum; and

- Not eligible for benefit payment once the Deductible is satisfied

Penalties will apply under the following circumstances:

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

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

Pharmacy Formulary Exception Process/Prior Authorization

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, 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 the Your Physician advises You that coverage for the Prescription Drugs or Related Supplies has been approved, You should contact the Pharmacy to fill the prescription(s).

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

If You disagree with a coverage decision, You may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered. Please see the section of this Policy entitled 'Claim determination procedures, And When You Have A Complaint, Appeal Or Grievance' regarding External Reviews. The External Review related to the denial of a Prescription Drug may be requested without having fulfilled the other levels of review, this is in compliance with the federal law.

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

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.

BENEFITS/COVERAGE (WHAT IS COVERED)

Medical Benefits (listed in alphabetical order)

Please refer to the Benefit Schedule for additional benefit provisions which may apply to the information 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 Members must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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

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

Note: Services from an Out-of-Network (Non-Participating) Provider are not covered except for Emergency Services.

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.

Ambulance Services

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

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

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

Ambulance transportation is covered only for emergency situations if the condition requires the use of medical services that only a licensed ambulance can provide.

Anesthesia for Dental Procedures

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

Charges for general anesthesia and for associated Hospital or facility charges for dental care for Insured Persons, are covered if the following apply: (a) the Insured Person has a physical, mental or medically compromising condition; (b) local anesthesia is ineffective for the Insured Person because of acute infection, anatomic variations or allergy; (c) the Insured Person is extremely uncooperative, unmanageable, anxious or uncommunicative with dental demands, and it is deemed sufficiently important that dental care cannot be deferred; or (d) the Insured Person has sustained extensive orofacial and dental trauma.

Autism Spectrum Disorders Treatment

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)
Benefits are payable for the treatment of Autism Spectrum Disorders.
The following services are covered:

- Outpatient physical, occupational and speech therapy in a medical office when prescribed by a physician as medically necessary.
- ABA therapy, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers.

Bariatric Surgery

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)
Coverage is provided for Medically Necessary bariatric surgery, subject to all Plan referral and Authorization requirements.

Cardiac and Pulmonary Rehabilitation Services

(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 Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

Cleft Lip-Cleft Palate

Benefits are payable for or in connection with cleft lip/cleft palate for newborns and where appropriate, to older children and adults when considered Medically Necessary. Benefits will include: (a) oral and facial surgery, surgical management, and follow-up care by plastic and oral surgeons; (b) prosthetic treatments such as obturators, speech appliances, and feeding appliances; (c) medically necessary orthodontic treatment; (d) medically necessary prosthodontic treatment; (e) habilitative speech therapy; (f) otolaryngology treatment; and (g) audiological assessments and treatments.

Clinical Trials

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 cancer, disabling, progressive or life-threatening conditions for an Insured who meets the following requirements:

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

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

The clinical trial must meet one of the following requirements:

1. Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
    i. An institute or center of the National Institutes of Health,
    ii. The Food and Drug Administration,
    iii. The Department of Veterans' Affairs, or
    iv. The Department of Defense.
    v. The Department of Energy
    vi. The Centers for Disease Control and Prevention.
    vii. The Agency for Health Care Research and Quality.
    viii. The Centers for Medicare & Medicaid Services.
    ix. cooperative group or center of any of the entities described in clauses (i) through (vi) or the Department of Defense or the Department of Veterans Affairs.
    x. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
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;
3. Costs for the management of research relating to the clinical trial or study;
4. Any portion of the clinical trial or study that is paid for by a government or a bio-technical, pharmaceutical, or medical industry;
5. Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
6. Extraneous expenses related to participation in the clinical trial; or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur.

Dental Care

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)
This Policy provides benefits for dental care for an accidental Injury to natural teeth, subject to the following:

- services must be received during the 6 months following the date of Injury;
- 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.

Diabetes Treatment

Benefits are payable for Diabetes Equipment, Diabetes Self-Management Training and Diabetes Pharmaceuticals and Supplies for insulin and non-insulin dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- Charges for Durable Medical Equipment (DME), including podiatric appliances, related to diabetes; any plan limit on DME will not apply to DME related to diabetes. Insulin pumps and accessories
- Charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
  (a) Medically Necessary 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 related to diabetes management.

Durable Medical Equipment

Your plan provides benefits for Covered Expenses for charges made for purchase or rental of durable medical equipment that is ordered and prescribed by a Physician, and provided by a vendor approved by Cigna for use outside a Hospital or other health care facility.

For the purposes of this benefit, Durable Medical Equipment means items which are designed for and able to withstand use by more than one person, customarily serve a medical purpose, generally are not useful in the absence of Injury or Illness, are appropriate for use in the home, and are not disposable.

Durable medical equipment includes, but is not limited to:

- Bed related items: bed trays, over-bed tables, bed wedges, pillows, custom bedroom equipment, and mattresses;
- Bath related items: bath lifts, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, handheld showers, and bath mats;
- Chairs, lifts and standing devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient fits (mechanical or motorized – manual hydraulic lifts are covered if patient requires two-person transfer), and auto tilt chairs;
- Fixtures to real property: ceiling lifts and wheelchair ramps;
- Car/van modifications;
- Blood/injection related items: blood pressure cuffs, nova pens and needleless injections;
- Other equipment: heat lamps, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, enuresis alarms, magnetic equipment scales (baby and adult), and stair gliders.
- 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;
- Not primarily for comfort or hygiene;
- Not for environmental control;
- Not for exercise;
- 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 and whether the equipment falls under a rental or purchase category.

Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician. Rental charges that exceed the reasonable purchase price of the equipment are not covered, unless the equipment has previously been determined by Cigna to fall into a continuous rental category and require frequent maintenance and servicing.

Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Early Intervention Services

Your Plan provides coverage for Medically Necessary Early Intervention Services delivered by a Qualified Early Intervention Service Provider to an eligible individual. Early intervention services specified in an IFSP shall qualify as meeting the standard for Medically Necessary health care services as used by private health insurance plans. The individual must reside within Colorado to be eligible for this program.

An "IFSP**"** means a written Individualized Family Service Plan that authorizes early intervention services to an eligible individual and the individual's family. A "Qualified Early intervention Service Provider" or "Qualified Provider" means a person or agency that provides early intervention services and is listed on the Registry of Early Intervention Services.

Coverage shall be available annually to an eligible individual who has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development.

Early Intervention Services do NOT include:

- Non-emergency medical transportation;
- Respite care;
- Service coordination other than case management services; and
- Assistive technology. However, assistive technology may be covered by the policy's durable medical equipment benefit provisions.

The coverage will not be subject to Deductibles or Copayments.

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.

External Prosthetic Appliances and Devices

(Please refer to the 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 Illness, Injury, or congenital defect.
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.

Foreign Country Providers Treatment

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

Cigna does not accept assignment of benefits from Foreign Country Providers. You and Your Family Member can file a claim with Cigna for services and supplies from a Foreign Country Provider but any payment will be sent to the Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. The Insured Person at their expense is responsible for obtaining an English language translation of Foreign Country Provider claims and any medical records that may be required. Benefits are subject to all terms, conditions, limitations, penalties and exclusions of this Policy and will not be more than would be paid if the service or supply had been received in the United States.

Genetic Testing

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

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

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

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

Habilitative Services

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

This Policy provides benefits for Covered Expenses for services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado's EHB benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration." Defining habilitative benefits in this manner provides habilitative benefits on par with those currently offered in rehabilitation and reflects current utilization in the rehabilitative arena. Services 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:

- 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.

Hearing Services

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

This Plan provided benefits for hearing services as follows:

- Hearing testing and related examination to determine the need for hearing correction for all ages.

- Hearing aids and audiological services for children up to eighteen (18) years of age who have a hearing loss that has been verified by a licensed Physician and by a licensed audiologist.
- Benefits will be paid the same as any other medical condition. Benefits are subject to Prior Authorization and are covered benefits only if deemed Medically Necessary.

Hearing aids for children up to eighteen (18) years of age shall be medically appropriate to meet the needs of the Insured Person according to accepted professional standards.

Coverage shall include the purchase of the following:

- Initial one pair of hearing aids and one pair of replacement hearing aids not more frequently than every 3 years;
- A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child;
- Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

Coverage does NOT include:

- Tests to determine an appropriate hearing aid model
- Hearing aids and tests to determine their usefulness

Home Health Care

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)
Benefits are provided when Home Health Services are necessary as an alternative to hospitalization or in place of hospitalization (prior hospitalization is not required). The Home Health Services must be rendered pursuant to the written order of the Physician treating the Illness or Injury that necessitates Home Health Services and under a plan of care established by the Physician in collaboration with a Home Health services provider. Services must be clinically indicated; may not exceed 28 hours per week combined over any number of days per week; and must be for less than 8 hours per day. Additional time up to 35 hours per week but less than 8 hours per day may be approved on a case-by-case basis.

The following services are covered:

- Professional nursing services of a registered nurse.
- Certified nurse aide services under the supervision of a Registered Nurse or a qualified therapist.
- Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and audiology, or respiratory and inhalation therapy.
- Nutrition counseling by a nutritionist or dietitian.
- Medical social services.
- Necessary medical supplies provided by the Home Health Agency
- Prosthesis and orthopedic appliances.
- Rental or purchase of durable medical equipment supplied by the Home Health Agency.
- Drugs, medicines or insulin supplied by the Home Health Agency.

Exclusions and Limitations:
The following items are not covered expenses:

- Services or supplies for personal comfort or convenience, including homemaker services.
- Services related to well-baby care.
- Food services or meals with the exception of dietary counseling or tube feedings.

Special Services Program:
If an Insured Person is diagnosed with a terminal illness with a life expectancy of 1 year or less, but is not ready to elect hospice care, the Insured Person is eligible for the Special Services Program, which allows receipt of up to 15 home health care visits per lifetime. The Insured Person is covered under the Special Services Program until he or she elects hospice care coverage. The Insured Person may or may not be homebound or have skilled nursing care needs; or may only require spiritual or emotional care. Services are provided by professionals with specific training in end-of-life issues.

Hospice Services

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)
Benefits for Hospice services will be provided when such services are provided under the active management of a Hospice which is responsible for coordinating all Hospice Care services, regardless of the location or facility in which such services are furnished. Benefits are provided only for Insured Persons who are terminally ill and have a life expectancy of six months or less; however, should the patient exceed the six month prognosis for life expectancy, benefits will continue at the same rate for one additional Benefit Period, as defined in the Policy. After the exhaustion of three Benefit Periods, Our case management staff will work with the patient's attending Physician and the Hospice's medical director to determine the appropriateness of continuing Hospice Care.

A Physician must provide a written certification of the Insured Person's Illness, including a prognosis for life expectancy and the appropriateness for Hospice Care. We may also require a copy of the Insured Person's plan of care and any changes made to the Hospice Level of Care or to the plan of care. Services and charges incurred in connection with an unrelated Illness or Injury will be processed in accordance with Policy provisions applicable to all other Illnesses and Injuries.

Routine Home Care Hospice Services:
Benefits will be provided for charges for the following Routine Home Care Hospice services under the Hospice plan of care:

- Intermittent and 24-hour on-call professional nursing services provided by or under the supervision of a registered nurse.
- Intermittent and 24-hour on-call social/counseling services.
- Certified nurse aide services or nursing services delegated to other persons pursuant to section 12-38-132, C.R.S.

All Other Hospice Services:
Benefits will be provided as any other medical condition for the following additional Hospice Services:

- Short-term General Inpatient (acute) Hospice care or Continuous Home Care that may be required during a period of crisis, for pain control or symptom management. Prior Authorization is required except for emergencies, weekends or holidays or when the transfer to the higher level of care was necessary during Our non-business hours, provided the Hospice obtains authorization on the first business day thereafter.
- Medical supplies.
- Drugs and biologicals.
- Prosthesis and orthopedic appliances.
- Oxygen and respiratory supplies.
- Diagnostic testing.
- Rental or purchase of durable equipment.
- Transportation.
- Physician services.
- Therapies including physical, occupational, speech and respiratory.
- Nutritional counseling by a nutritionist or dietitian.
- Bereavement support services for the family of the deceased person during the 12-month period following death

- Palliative drugs in accord with the drug formulary guidelines
- Services of volunteers

Hospital or Free-Standing Outpatient Surgical Facility Services and Supplies

(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.
- Private duty nursing as part of inpatient hospital care, covered only if determined to be medically necessary.
- Physical, occupational and speech therapy is covered as part of inpatient hospital care if, in the judgment of a physician, significant improvement is achievable within a 2 month period.
- Outpatient services and supplies including those in connection with Emergency Services, outpatient surgery and outpatient surgery performed at a Free-Standing Outpatient Surgical Facility.
- Diagnostic/Therapeutic Lab and X-rays.
- Anesthesia and Inhalation Therapy.

Payments of Inpatient Covered Expenses are subject to these conditions:

- Services must be those which are regularly provided and billed by the Hospital or Free-Standing Outpatient Surgical Facility.
- Services are provided only for the number of days required to treat the Insured Person's Illness or Injury.
- Note: No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Infertility Services

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

This Policy provides coverage for the following Services, including X-ray and laboratory procedures:

- Services for diagnosis and treatment of involuntary infertility; and
- artificial insemination, except for donor semen, donor eggs and Services related to their procurement and storage.

Mastectomy and Related Procedures

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)
This Policy provides benefits for Covered Expenses for hospital and professional services under this Policy for mastectomy and lymph node dissection for the treatment of breast cancer and for the treatment of physical complications of all stages of mastectomy, including lymphedemas, whether or not the mastectomy occurred while the Insured Person was covered under this Policy. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer.

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

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses.

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

Medical Foods

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

Benefits are payable for Medical Foods to treat inherited enzymatic disorders, caused by single gene defects involved in the metabolism of amino, organic, and fatty acids, including, but not limited to, the following diagnosed conditions: Phenylketonuria; maternal Phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; and propionic acidemia. “Medical Foods” means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy that are specifically designated and manufactured for the treatment of inherited enzymatic disorders, not including cystic fibrosis or lactose-intolerant or soy-intolerant disorders. Coverage will be the same for Medical Foods purchased in-network or out-of-network.

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

(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 (including biologically based mental illnesses or 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 that can be improved by standard medical practice.
- The Insured Person must be under the direct care and treatment of a Physician for the condition being treated.
- Services must be those which are regularly provided and billed by a Hospital or a Physician.
- Services are covered only for the number of days or visits which are Medically Necessary to treat the Insured’s condition.
- Inpatient services must be received in a Hospital or Residential Treatment Facility.

Multidisciplinary Rehabilitation Services Facilities Services and Supplies

We will cover treatment for up to two (2) months per condition, per year, in an organized, multidisciplinary rehabilitation services program in a designated facility or a Skilled Nursing Facility. We cover multidisciplinary rehabilitation services while You are an inpatient in a designated facility.

- Diagnostic/Therapeutic Lab and X-rays.
- Anesthesia and Inhalation Therapy.

Payments of Inpatient Covered Expenses are subject to these conditions:

- Services must be those which are regularly provided and billed by the Hospital or Multidisciplinary Rehabilitation 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.

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”).

The Policy provides benefits for Hospital and professional services as described in this Policy for:

- An Insured Person who receives the organ or tissue.
- An Insured Person who donates the organ or tissue.

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

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

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

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

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

Cornea transplants are **not** available at Cigna LIFESOURCE Transplant Network® Facilities. All other transplant services are covered when received at Cigna LIFESOURCE Transplant Network® Facilities. Transplant services, including cornea, received from non-LIFESOURCE Participating Provider facilities that are specifically contracted for those services are payable at the In-Network level
The Cigna LIFESOURCE Transplant Network® Facility benefit includes the following **travel expense benefits** that will be provided for:

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

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

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

Cigna LIFESOURCE Transplant Network® Facility Benefit Exclusions and Limitations

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

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

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

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

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

- Transportation expenses, lodging and meals when the Cigna LIFESOURCE Transplant Network® Facility is less than 100 miles from the Insured Person's home.
- Charges incurred by more than one travel companion.
- Charges incurred by the Insured Person and a travel companion for transportation, lodging and meals other than what is reasonable and necessary for the treatment Plan.
- Charges in connection with the travel allowance benefit that is not incurred for the treatment Plan at a Cigna LIFESOURCE Transplant Network® Facility, except travel days.
- Charges incurred for transportation for a travel companion other than the trip required to accompany the Insured Person to and from the Facility.
- Charges for the repair or maintenance of a motor vehicle.
- Personal expenses incurred to maintain the Insured Person and a travel companion's residence while the Insured Person and a travel companion are traveling to and from the Facility and during the Insured Person's length of stay. Some examples of these personal expenses include, but may not be limited to: child care costs, house sitting costs, or pet kennel charges.
- Charges for personal comfort or convenience items.
- Charges for alcohol, drugs or tobacco.
- Reimbursement of any wages lost by the Insured Person and a travel companion for the treatment Plan.
- Travel expenses incurred while receiving treatment at a facility that is not designated as a Cigna LIFESOURCE Transplant Network® Facility.

Orthopedic Appliances

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

An orthopedic appliance is a rigid or semi-rigid device used to support, align, prevent or helps to increase the use of a malfunctioning body part or extremity, which limits or stops motion of a weak or poorly functioning body part. An example of an orthopedic appliance is a knee brace. Benefits are provided for the purchase, fitting, needed or orthopedic appliances. Coverage also includes adjustments and repairs provided the adjustments or repairs are not the result of misuse or loss. Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the member.

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 "Eligibility".

The mother and her newborn child shall be entitled to inpatient Hospital coverage for a period of 48 hours following an uncomplicated vaginal delivery, if 48 hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning; and 96 hours following an uncomplicated delivery by cesarean section, if 96 hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning. 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, including one newborn home visit during the first week of life if the newborn is released from the Hospital less than 48 hours after delivery.

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, the We may provide benefits for a shorter stay if the attending provider (*e.g.,*the Physician, nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

Preventive Care Services

(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 the following:

- Routine physical exams
- An annual breast cancer screening with mammography, annual Pap test annual prostate cancer screening, including a prostate –specific antigen (PSA) blood test, colorectal screening for all high risk individuals and full cost of cervical cancer vaccine.
- Influenza and pneumococcal vaccinations
- Items or services that have an A or B rating in current recommendations of the U. S. Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- For women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration

Detailed information is available at: www.healthcare.gov

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

Professional and Other Services

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)
The Policy provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- Services of an anesthesiologist or an anesthetist;
- Consultations with clinical pharmacists
- Medical social services
- 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 un-replaced blood and blood products;
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification

Rehabilitative Therapy for Insured Persons with Congenital Defects and Birth Abnormalities

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

Benefits are payable for the care and treatment of congenital defects and birth abnormalities. Medically Necessary physical, occupational, and speech therapy will be covered for Insured Persons with congenital defects and birth abnormalities. Therapy will be provided without regard to whether a condition is acute or chronic, and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

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

(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 or 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.

Skilled Nursing Facility Services and Supplies

(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.
- Physical, occupational and speech therapy is covered as part of skilled nursing care if, in the judgment of a physician, significant improvement is achievable within a 2 month period.

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.

Smoking Cessation

This Policy provides benefits for Covered Expenses for Smoking Cessation in accordance with "A" or "B" recommendations of the U.S. Preventive Services Task Force.

Telehealth/Telemedicine

Benefits are payable as any other medical condition for telemedicine.

Telemedicine, includes the delivery of medical services and any diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication. 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.

Temporomandibular Joint Dysfunction (TMJ) Treatment

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

Medical services for TMJ are covered on the same basis as any other medical condition. Dental services (i.e. dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums), or orthodontic services (i.e. braces and other orthodontic appliances) are not covered by this Policy for any diagnosis, including TMJ.

Prescription Drug Benefits

Covered Expenses

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

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

What Is Covered

- Outpatient Drugs and medications that federal and/or applicable State of Colorado laws restrict to sale by Prescription only, except for 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; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.
- Contraceptive Drugs and devices approved by the FDA. Currently the Food and Drug Administration (FDA) has approved 18 different methods of contraception. All FDA approved methods of contraception are covered under this policy without cost sharing as required by federal and state law.
- 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.
- Off-label use of cancer medication if a) the drug is recognized for the treatment of that cancer in authoritative reference compendia as identified by the secretary of the U.S. Department of Health and Human Services; and b) the treatment is for a covered condition.
- All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.
- 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 days’ supply indicated in the “Limitations” section below.
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification

Pediatric Vision Benefits

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.

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

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

What Is Covered

In-Network Covered Benefits for Insured Persons less than 20 years of age include:

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

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

Cigna Vision Providers

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

LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

Excluded Services

Cigna may not deny, exclude, or otherwise limit coverage for Medically Necessary services, as determined by an Insured Person's medical provider, if the item or service would be provided based on current standards of care and as a covered benefit to another Insured Person without regard to their sexual orientation.

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

- Services obtained from an Out-of-Network (Non-Participating) Provider, except for Emergency Services.
- Any amounts in excess of maximum amounts of Covered Expenses stated in this Policy.
- Services not specifically listed as Covered Services in this Policy.
- Services for treatment of complications of non-covered procedures or services.
- Services or supplies that are not Medically Necessary.
- Services or supplies that Cigna considers to be for Experimental Procedures or Investigative Procedures.
- Services received before the Effective Date of coverage.
- Services received after coverage under this Policy ends.
- Services for which You have no legal obligation to pay or for which no charge would be made if You did not have health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Insured Person does not claim those benefits.
- Conditions caused by: (a) an act of war (declared or un-declared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the military service of any country; (d) an Insured Person participating in an insurrection, rebellion, or riot; (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a felony (whether or not charged) or as a direct result of the Insured Person being engaged in an illegal occupation.
- Any services provided by a local, state or federal government agency, except (a) when payment under this Policy is expressly required by federal or state law.
- Any services required by state or federal law to be supplied by a public school system or school district.
- Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid or medical assistance benefits under the Colorado Medical Assistance Act, Title 25.5, Articles 4, 5, and 6, C.R.S.). 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 medically necessary and listed as covered in this plan.
- Professional services or supplies received or purchased from Yourself.
- Custodial Care.
- Private duty nursing except when provided as part of the Home Health Care Services or Hospice Services benefit in this Policy or as specifically stated in the section of this Policy titled "Benefits/Coverage (What is Covered)".

- Inpatient room and board charges in connection with a Hospital stay primarily for environmental change or physical therapy; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
- Services received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental health.
- Complementary and alternative medicine services, including but not limited to: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; meditation; visualization; acupuncture; acupressure; reflexology; rolfing; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnosis; energy-balancing; breathing exercises; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf; and any other alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. Services specifically listed as covered under "Short Term Rehabilitative Therapy" and "Habilitative Therapy" are not subject to this exclusion.
- Any services or supplies provided by or at a place for the aged, a nursing home, or any facility a significant portion of the activities of which include rest, recreation, leisure, or any other services that are not Covered Services.
- Assistance in activities of daily living, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or convalescent care.
- Services performed by unlicensed practitioners or services which do not require licensure to perform, for example mediation, breathing exercises, guided visualization.
- Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Services which are self-directed to a free-standing or Hospital based diagnostic facility.
- Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service, or
  - Is not actively involved in your medical care after the service is received.

  This exclusion does not apply to mammography.
- Treatment of Mental, Emotional or Functional Nervous Disorders or psychological testing, except as specifically provided in this Policy. However, medical conditions that are caused by behavior of the Insured Person and that may be associated with these mental conditions are not subject to these limitations.
- Dental services, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- Orthodontic Services, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction , except for treatment for medically necessary orthodontia for a person born with a cleft lip or cleft palate..
- 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, excludes medically necessary treatment of cleft lip, cleft palate.
- Hearing aids, except as specifically stated in this Policy, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), limited to the least expensive professionally adequate device. A hearing aid is any device that amplifies sound.
- Routine hearing tests except as specifically provided in this Policy under "Benefits/Coverage (What is Covered)".
- Genetic screening or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).

- 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.
- Cosmetic surgery or other services for beautification, to improve or alter appearance or self-esteem or to treat psychological or psychosocial complaints regarding one's appearance. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury, medically necessary surgery or congenital defect of a Newborn child, or to treat congenital hemangioma (port wine stains) on the face and neck of an insured person 18 years and younger, 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.
- Nonmedical 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, except as specifically stated in this Policy. This exclusion does not apply to health education services for chronic diseases and self-care on topics such as stress management and nutrition.
- Services and procedures for redundant skin surgery including abdominoplasty/panniculectomy, removal of skin tags, acupressure, acupuncture, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; varicose veins; rhinoplasty and blepharoplasty, regardless of clinical indications.
- Surgery or treatments to change characteristics of the body to those of the opposite sex.
- Any treatment, prescription drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire
- The following services related to the evaluation or treatment of fertility and/or Infertility, sterilization reversals; donor semen and donor eggs; ovum transplants; In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated 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 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, if not provided by an approved Participating Provider specifically designated to supply that specialty prescription. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition
- Orthopedic shoes (except when joined to braces), shoe inserts, foot orthotic devices (except for treatment as a result of diabetes).
- Services primarily for weight reduction or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Insured Person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction, except as otherwise stated in this Policy under "Bariatric Surgery".

- Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition, including those required by employment or government authority, physical exams required for or by an employer or for school, or sports physicals, except as otherwise specifically stated in this Plan.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Items which are furnished primarily for personal comfort or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.).
- Massage therapy
- Educational services except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.
- Nutritional counseling or food supplements, except as stated in this Policy.
- Durable medical equipment not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this Policy.
- Physical, and/or Occupational Therapy/Medicine except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and ' under Physical and/or Occupational Therapy/Medicine' in the section of this Policy titled " Benefits/Coverage (What is Covered)".
- 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 "Benefits/Coverage (What is Covered)".
- Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition; Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Routine foot care including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet, except as otherwise stated in this Policy.
- Charges for which We are unable to determine Our liability because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a standby Physician.
- Charges for animal to human organ transplants.
- Charges for elective abortions.
- Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

Prescription Drug Benefit 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 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 the medical benefits of this Plan and require Prior Authorization. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.;
- Infertility related drugs, except those required by the Patient Protection and Affordable Care Act (PPACA)
- Any drugs 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
- 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 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 to replace those lost, stolen, spilled, spoiled or damaged before the next refill date;
- Replacement of Prescription Drugs and Related Supplies due to loss or theft;
- Drugs used to enhance athletic performance;
- Drugs which are to be taken by or administered to the Insured Person while a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;

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

Prescription Drug Benefit 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 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
- 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.
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification.
- To a dosage and/or dispensing limit as determined by the P&T Committee.

Pediatric Vision Benefit Exclusions

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

Pediatric Vision Benefit Limitations

No payment will be made for more than one examination during a calendar year and one pair of lenses during two calendar years; or more than one pair of frames during two calendar years for any one person.

No payment will be made for expenses incurred for:

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

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

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

MEMBER PAYMENT RESPONSIBILITY

Benefit Schedule

Coinsurance amounts shown in the Benefit Schedule are Your responsibility after any applicable deducible or copayment has been met, unless otherwise indicated. Copayment amounts shown in the Benefit Schedule are also Your responsibility.

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.

In addition, no benefits are payable unless the Insured Person receives services from a Participating Provider, except in the case of initial treatment and Stabilization of a Medical Emergency, as indicated below under "Special Circumstances".

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.

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 his/her condition permits transfer to a Participating Hospital, services of a Non-Participating Hospital will no longer be covered.
- **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.

General Provisions

- 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(s) receives a service or supply for which the charge is made.

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

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 Copay or Coinsurance shown in the Benefit Schedule, after You have satisfied any applicable Deductible. Please refer to the Benefit Schedule for any applicable Copays or Coinsurance and Deductible(s).

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 health care 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.

CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Medical Claims

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 Emergency Services from Non-Participating Providers can be submitted by the provider if the provider is able and willing to file on Your behalf. If a Non-Participating Provider is not submitting on Your behalf, You must send Your completed claim form and itemized bills to the claims address listed on Your ID card.

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

Claim Forms: When We receive the notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days after the giving of such notice, the claimant shall meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section. You may also get the required claim forms from www.cigna.com under HealthCare, Important Forms or by calling Member Services using the toll-free number on Your identification card.

Claim Reminders:

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

Proof of Loss: You must give Us written proof of loss within 15 months after the date of the loss, except in absence of legal capacity. 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.

Payment for services provided by a Participating Provider is automatically assigned to the provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating Provider is responsible for filing the claim and We will make payments to the provider for any benefits payable under this Policy. Payment for any Covered Expenses for Emergency Services from a Non-Participating Provider is payable to the Insured Person unless assignment is made as outlined below. 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 to a provider licensed and practicing within the United States.

We assume no responsibility for the validity or effect of an assignment. You may revoke the assignment by providing a written revocation to Us and to the provider. Revocation will be effective only as to charges incurred after receipt by Us and the provider.

Claims of Dependent Children: Claims of a covered Dependent child may be filed by either parent or by the state department of social services in the case of an assignment under section 26-13-106, CRS, who submits valid copies of medical bills. A claim submitted by a custodial parent who is not an Insured Person under this policy shall be deemed a valid assignment of benefits for payment to the health care provider.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss, subject to the section below on "The Claims Process.".

Payment of Claims: Subject to any written direction of the insured in the application or otherwise, all or a portion of any benefits provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. Any benefits due You which are unpaid at Your death will be paid to Your estate.

Cigna is entitled to receive from any provider of service information about You which is necessary to administer claims on Your behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, You have authorized every provider furnishing care to disclose all facts pertaining to Your care, treatment, and physical condition, upon Our request. You agree to assist in obtaining this information if needed.

Payments of benefits under this Plan neither regulate the amounts charged by providers of medical care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

1. **The Claims Process:** Within 30 days after You receive Covered Services, or as soon as reasonably possible, You or someone on Your behalf, must notify Us in writing of Your claim.
2. We will pay, deny or settle clean claims within 30 days after We receive Your written notice of an electronic claim or 45 days after We receive Your written notice of a non-electronic claim,
3. If We receive a claim that requires additional information We will, within 30 calendar days after receipt of the claim, give the Provider, Policyholder, Insured Person, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.
    - The person receiving a request for such additional information shall submit all additional information requested by US within 30 calendar days after receipt of such request.
    - Notwithstanding any provision of an indemnity policy to the contrary, We may deny a claim if a Provider receives a request for additional information and fails to timely submit additional information requested, subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection
4. Absent fraud, all claims other than clean claims referenced in #2 above must be paid, denied or settled within 90 calendar days after We receive it.

Claim Determination Procedures Under Federal Law (Provisions of the laws of Colorado may supersede.)

Colorado law defines “Utilization Review” as a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. Utilization Review also includes reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation. The following information provides further detail on utilization review procedures.

Procedures Regarding Medical Necessity Determinations

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

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

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

Pre-service Medical Necessity Determinations

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

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

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

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

Concurrent Medical Necessity Determinations

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

Post-service Medical Necessity Determinations

When an Insured Person or their representative requests a Medical Necessity determination after services have been rendered, Cigna will notify them of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify the Insured Person or their representative within 30 days after receiving the request. This notice will include the reason for the requested extensions and 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.

Prescription Drug Claims

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.

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 service 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 myCigna.com.

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

Pediatric Vision Claims

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.

Assignment of Pediatric Vision Claim Payments:

Pediatric Vision 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.

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
Claims 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 POLICY PROVISIONS

Third Party Liability

You agree to advise Us, in writing, within a reasonable time of Your claim against the third party and to take such action, provide such information and assistance, and execute such documents as We may reasonably require to facilitate enforcement of the claim. You also agree to take no action that may prejudice the rights or interests of Us under this Policy. Failure to provide notice of a claim or to cooperate with Us, or actions that prejudice our rights or interests, may be considered to be a material breach by Us and may subject You to legal action.

We may have a right to a lien, to the extent of benefits advanced, upon any recovery that You receive from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this Policy for the treatment of the Illness, disease, Injury or condition for which the third party is liable. Our right to a lien on Your recovery is limited only to that amount in excess of Your full compensation for all damages arising out of the claim.

In addition, if an Insured Person incurs expenses for Illness or Injury that occurred due to the negligence of a third party:

* We have the right to reimbursement for all benefits we paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Insured Person, Insured Person's parents, if the Insured Person is a minor, or Insured Person's legal representative as a result of that Illness or Injury; and
* We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits we paid for that Illness or Injury.
* We shall have the right to first reimbursement out of all funds the Insured Person, the Insured Person's parents, if the Insured Person is a minor, or the Insured Person's legal representative, is or was able to obtain for the same expenses we have paid as a result of that Illness or Injury.

You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

Alternate Cost Containment Provision

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

Other Insurance 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.

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.

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

- 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.

- This reduction will not apply to any Insured Person except as listed under “Cigna will pay as the Secondary Plan…”above

Terms of the Policy

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

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except 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.

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

If You did not purchase Your plan from a 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 day of the grace period . Coverage will continue during the grace period unless We notify the Insured Person at the billing address listed in Our records at least 30 days prior to any premium due date that We do not intend to renew this Policy, or the Insured Person notifies Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy in accordance with the Cancellation provision below. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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.

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 date 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.

If any Insured Person makes a written request to Us for a copy of the application, We will deliver or mail to the Insured Person a copy of the application within 15 days of receipt of the request.

Exception for Insured Persons deployed by or called to Active Duty in the United States military: Upon application for reinstatement, We will provide the Policyholder deployed by or called to active duty in the military the same benefits in effect before the policy lapsed. Premium will not be increased unless rate increases are applicable to all Policyholders. The Policyholder will not be subject to Pre-existing Conditions limitations.

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 intentional misrepresentation of a material fact 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 be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Incontestability: After two years from the date of issue of this Policy no misstatements, except fraudulent misstatements made by the applicant in the application for the Policy, shall be used to void the Policy or to deny a claim commencing after the expiration of such two-year period.

Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Arbitration: Except as provided by C.R.S. § 10-16-202(12), and to the extent permitted by law, the parties may agree to submit a controversy arising out of, connected with and/or relating in any way to this Policy to arbitration administered by the American Arbitration Association ("AAA") upon written notice. Such arbitration shall be governed by the AAA Commercial Arbitration Rules then in effect, to the extent that such provisions are not inconsistent with the provisions of this section. A single arbitrator (the "Arbitrator") shall decide the arbitration. The arbitration including, without limitation, the existence, nature, resolution and/or outcome, shall be held and conducted in strict confidence. The arbitration hearing shall be held within 30 days following appointment of the Arbitrator, unless otherwise agreed to by the parties. The Arbitrator shall render his/her final decision within 30 days after the conclusion of the arbitration hearing. The decision of the Arbitrator shall be enforceable in any court of competent jurisdiction. In the case of an arbitration, the Arbitrator shall not have authority to conduct an action in respect of any purported class, collective, representative, multiple plaintiff or similar proceeding, 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.

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 the Insured Person resides on such date or a federal statute, it is amended to conform to the minimum requirements of those statutes.

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

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

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

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

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

Cigna
Individual Services
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(s) receives a service or supply for which the charge is made.

- We will pay all benefits of this Agreement directly to Participating Hospitals, Participating Physicians, and all other Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case We will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured Person assigns benefits in writing no later than the time of filing proof of loss (claim), except for Foreign Country Provider claims. However, 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.

- If We receive a claim from a Foreign Country Provider for a Medical Emergency, any eligible payment will be sent to the Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured Person for those services.

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

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

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

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

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

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

- If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium

received under the other Policy covering the time period both policies were in effect. However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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

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

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.

TERMINATION/NON-RENEWAL/CONTINUATION

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 meets the requirements listed in the Eligibility Requirements section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

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

Cancellation

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period for plans not purchased from the Marketplace or the 61 day grace period for plans purchased from a Marketplace, or the 90 day grace period for insured persons receiving the Advanced Premium Tax Credit. .
2. On the first of the month following Our receipt of Your written notice to cancel. If You purchased Your plan on a state exchange, We will cancel this Policy in accordance with Your written notice to cancel provided You provide notice at least fourteen days before the requested effective date of termination. If You provide Your written notice to cancel less than fourteen days before the requested date of termination, the effective date of termination will be no later than fourteen days after You provided the written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception, or intentional misrepresentation of material fact in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class. In this event, Colorado 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 Colorado, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation. Your coverage will be continued through Your first renewal period but not for more than 12 months after We send You the notice.
7. When You no longer live in the Service Area.
8. When Cigna determines that any premium payment for this Policy is being paid directly or indirectly from any source other than You, Your Family Members or an Acceptable Third Party Payor; however, if You, Your Family Members or an Acceptable Third Party Payor make all premium payments for this Policy that are due after the date of Cigna's determination, the Policy shall remain in effect, subject to all other terms and conditions contained herein.

Any cancellation shall be without prejudice for any claim for Covered Expense incurred before cancellation. Except for fraud or intentional misrepresentation, We will provide You notice of the cancellation at least 30 days in advance of the cancellation of the Policy, unless a longer notice period is required by law.

Continuation

If an Insured Person's eligibility under this Policy would terminate due to the Insured's death, divorce or other reason for the Insured's ineligibility stated in the Policy or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person has the right to continuation of his or her insurance. Coverage will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. In such a case, coverage will continue without evidence of insurability. Also, if an Insured Person's eligibility under this Policy would terminate due to the Insured's death, divorce or other reason for the Insured's ineligibility stated in the Policy, except for the Insured's failure to pay premium, such termination would be considered a triggering event and the Insured Person could enroll during a special enrollment period if the Insured Person did not exercise their continuation right. 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: 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. Please see "Eligibility" for further information regarding Special Enrollment Periods.

APPEALS AND COMPLAINTS

WHEN YOU HAVE A COMPLAINT OR AN ADVERSE DETERMINATION APPEAL

Complaint and Appeal Process

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

Cigna wants the Insured Person to be completely satisfied with the coverage received. That is why Cigna established a process for addressing the Insured Person's concerns and resolving problems.

Start with Customer Service

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

Cigna will do their best to resolve the matter on the Insured Person's initial contact. If Cigna needs more time to review or investigate the concern, Cigna will get back to the Insured Person as soon as possible, but in any case within 30 days.

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

Appeals Procedure

To initiate an appeal, the Insured Person must submit a request for an appeal in writing within 365 days of receipt of a denial notice to the following address:

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

The Insured Person should state the reason why the Insured Person feels the appeal should be approved and include any information supporting the appeal. If the Insured Person is unable or chooses not to write, the Insured Person may ask to register the appeal by telephone. The Insured Person may call Cigna at the toll-free number on their Benefit Identification card, explanation of benefits or claim form. The Insured Person may also register the appeal by an arranged appointment or walk-in interview.

Colorado law provides one level of appeals for internal appeals of an adverse determination. Adverse determination means:

- A denial of a preauthorization for a covered benefit;
- A denial of a request for benefits for an individual on the ground that the treatment or covered benefit is not medically necessary, appropriate, effective, or efficient or is not provided in or at the appropriate health care setting or level of care;
- A rescission or cancellation of coverage under a health coverage plan that is not attributable to failure to pay premiums and that is applied retroactively;
- A denial of a request for benefits on the ground that the treatment or service is experimental or investigational; or
- A denial of coverage to an individual based on an initial eligibility determination.

Requests for appeal regarding an adverse determination of the Insured Person's issue will be conducted by a Committee, which consists of one or more people not previously involved in the prior decision. The Committee will consult with at least one Physician 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 the Insured Person's appeal, and b) not a subordinate of previous decision makers.

The Insured Person has the following rights: (1) to attend the Committee review in person, or via teleconference or video conference; (2) to present their situation to the Committee in person or in writing; (3) to submit supporting material both before and at the Committee review; (4) to ask questions of any Cigna representative prior to the review; and (5) to question any reviewer at the review; and (6) to be assisted or represented by a person of their choice.

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

The Insured Person will be notified in writing of the decision within five working days after the decision is made, and within the review time frames above if Cigna or the Committee does not approve the requested coverage.
The Insured Person may request that the appeal process be expedited if the time frames under this process: (a) would seriously jeopardize the Insured Person's life, health or ability to regain maximum function or, in the opinion of your Physician would cause severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay. If the Insured Person requests that the appeal be expedited based on (a) above, the Insured Person may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to the Insured Person's medical condition.

Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. Cigna's Physician reviewer will consult with a Physician reviewer in the same or similar specialty as the care under consideration to make a decision. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

Standard External Review Process for Medical Necessity Adverse Decisions

If the Insured Person remains dissatisfied with an adverse determination decision of Cigna and has completed the internal appeal review, the Insured Person may submit a written request for External Independent Review (EIR). Cigna will pay the cost of the EIR and there is no restriction on the minimum dollar amount of a claim for it to be eligible for external review. The Insured Person has four months after the date of receipt of Cigna's final adverse determination to submit a written request for EIR. All requests for external review must be in writing to Cigna and must include a completed external review request form. All requests must also include a signed consent, authorizing Cigna to disclose protected health information, including medical records, pertinent to the external review. Whenever Cigna receives an incomplete standard request for external review that fails to meet Cigna's filing procedures, Cigna shall notify the Insured Person of this failure as soon as possible, but in no event later than five days following the date the incomplete request was received.

Within two working days of receipt of the Insured Person's request for EIR, Cigna will deliver a copy of the request to the Commissioner. If Cigna decides to reverse the final adverse determination before sending the Insured Person's request to the Commissioner, The Insured Person will be informed within one working day of Cigna's decision by facsimile, telephone or other electronic means, followed up in writing.

Within two working days of receiving the Insured Person's request for EIR from Cigna, the Commissioner will assign an independent external review entity to conduct the external review. Upon assignment, the Commissioner will notify Cigna, electronically, by facsimile, or by telephone, followed up in writing, of the name and address of the independent external review entity to which the appeal should be sent. Within one working day of receiving the notice from the Commissioner, Cigna will provide the Insured Person either electronically, by facsimile, or by telephone, followed up in writing, with a description of the independent external review entity and how to provide the Commissioner with documentation regarding any potential conflict of interest with the independent external review entity. Within two working days of receipt of notice from Cigna concerning the independent external review entity, The Insured Person may provide the Commissioner with documentation regarding a potential conflict of interest of the independent external review entity, electronically, by facsimile, or by telephone, followed up in writing. If the Commissioner determines that the independent external review entity presents a conflict of interest, the Commissioner shall assign, within one working day, another independent external review entity to conduct the external review. Upon this reassignment, the Commissioner will notify Cigna, electronically, by facsimile, or by telephone, followed up in writing, of the name and address of the new independent external review entity to which the appeal should be sent. The Commissioner will also notify the Insured Person in writing of the Commissioner's determination regarding the potential conflict of interest and the name and address of the new independent external review entity. . Within five business days of receipt of notice from CIGNA concerning the independent external review entity, the Insured Person may submit information directly to the EIR and the EIR will provide a copy of the information to CIGNA within one business day after receipt of the information.

Within five working days from the date Cigna receives notice from the Commissioner regarding the selection of the independent external review entity, Cigna will deliver the following to the assigned independent external review entity: (1) all relevant medical records; (2) a copy of any and all denial letters; (3) a copy of the signed consent form; (4) all documentation provided to Cigna by the Insured Person and/or a health care professional in support of the request for coverage; (5) criteria used and clinical reasons for the adverse decision; and (6) an index of all submitted documents. Within two working days of receipt of the material from Cigna, the independent external review entity will deliver to the Insured Person the index of all materials that Cigna has submitted to the independent external review entity. Cigna will provide the Insured Person, upon request, all relevant information supplied to the independent external review entity that is not confidential or privileged under state or federal law.

The independent external review entity will notify, the Insured Person, or their health care professional and Cigna of any additional medical information required to conduct the review. Within five working days of such a request, the Insured Person or their health care professional will submit the additional information, or an explanation of why the additional information is not being submitted to the independent external review entity and Cigna. If the Insured Person or their health care professional fail to provide the additional information or the explanation of why additional information is not being submitted within five working days, the independent external review entity will make a decision based on the information submitted by Cigna. If Cigna fails to provide the required documents and information within five working days, the independent external review entity may terminate the external review and make a decision to reverse Cigna's final adverse determination. Immediately upon the reversal, the independent external review entity will notify the Insured Person, Cigna and the Commissioner.

Upon receipt of any new information from you, Cigna may reconsider its final adverse determination that is the subject of the external review. The external review may only be terminated if Cigna decides to reverse its final adverse determination and provide coverage or payment for the health care service that was denied. Within one working day of Cigna making the decision to reverse its final adverse determination, Cigna will notify you, the independent external review, and the Commissioner of its decision, electronically, by facsimile, or by telephone, followed up in writing. The independent external review entity will terminate the external review upon receipt of the notice from Cigna.

Within 45 calendar days after the date of receipt of the request of the external review by Cigna, the independent external review entity will provide written notice of its decision to uphold or reverse Cigna's final adverse determination to the Insured Person, if applicable, to their designated representative, to Cigna, to their Physician and to the Commissioner.
Upon our receipt of the independent external review entity's notice of the decision reversing our final adverse determination, Cigna will approve the coverage that was the subject of the final adverse determination. For pre-service and concurrent care reviews, Cigna will approve the coverage within one working day. For post service review, Cigna will approve the coverage, within five working days. Cigna will provide written notice of the approval to the Insured Person within one working day of our approval of coverage. The coverage will be provided subject to the terms and conditions applicable to benefits under the plan.

Expedited External Review Process for Medical Necessity Adverse Decisions

The Insured Person or the Insured Person's designated representative may make a request with Cigna for an expedited external review if the Insured Person has a medical condition and if the time frame for completion of a standard external review would seriously jeopardize the Insured Person's life or health or ability to regain maximum function or, in the case of an Insured Person with a physical or mental disability, create an imminent and substantial limitation of the Insured Person's existing ability to live independently. The request for an expedited review must include a Physician certification that the Insured Person's medical condition meets the expedited review criteria.

Whenever Cigna receives an incomplete expedited request for external review that fails to meet Cigna's filing procedures, Cigna shall notify the Insured Person of this failure as soon as possible, but in no even later than twenty four hours after the incomplete request was received. Upon receipt of the Insured Person's request for an expedited external review, Cigna will notify and send a copy of the request to the Commissioner within one working day either electronically, by telephone, by facsimile or any other available expeditious method. Within one working day of receiving the request from Cigna, the Commissioner will assign an independent external review entity to conduct the review. Upon assignment, the Commissioner will inform Cigna of the name and address of the independent external review entity. Within one working day of receiving the notice from the Commissioner, Cigna will notify the Insured Person, electronically, by facsimile, or by telephone, followed up in writing. The notice will include a written description of the independent external review entity that the Commissioner has selected.

Immediately after receiving the request for an expedited external review, Cigna will provide all necessary documents and information considered in making the final adverse determination to the independent external review entity either electronically, by telephone, by facsimile or by any other available expeditious method. Cigna will provide to the Insured Person, upon request, all information submitted to the independent external review entity that is not confidential or privileged under state or federal law.

As soon as possible but no more than 72 hours after the date of receipt of the request for external review by Cigna, the independent external review entity will make a decision to uphold or reverse Cigna's final adverse determination and notify the Insured Person, the Insured Person's Physician, Cigna, and the Commissioner of the decision.
If the notice of the decision is not made in writing, the EIR must provide written confirmation of the decision within 48 hours after the date the notice of the decision is transmitted to the Insured Person, Insured Person's Physician, Cigna and the Commissioner.

Upon Our receipt of the independent external review entity's decision, Cigna will approve the coverage that was subject to the review immediately and will provide written notice of the approval to the Insured Person of the independent external review entity's notice. The coverage will be provided subject to the terms and conditions applicable to benefits under the plan. An expedited external review may not be provided for post service adverse determinations.

An external review decision is binding on Cigna and you, except to the extent Cigna and You have other remedies available under federal or state law. You may not file a subsequent request for external review involving the same plan's final adverse determination for which you have already received an external review decision.

Appeal to the State of Colorado

The Insured Person has the right to contact the Colorado Division of Insurance for assistance at any time. The Colorado Division of Insurance may be contacted at the following address and telephone number:

Colorado Division of Insurance
Department of Regulatory Affairs
1560 Broadway, Suite 850
Denver, CO 80202

1-800-930-3745

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 plan 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 your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit and (6) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. All written denials of requests for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient must be signed by a licensed physician/dentist familiar with standards of care in Colorado. A nurse or processor cannot sign a physician's/dentist's name 'on behalf of', a physician or dentist must sign, however an electronic signature is permitted. A final notice of adverse determination will include a discussion of the decision.

There may be other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office and the State insurance regulatory agency, or contact the Plan Administrator.

Relevant Information

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

INFORMATION ON POLICY AND RATE CHANGES

Premiums

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

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

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

If You did not purchase Your plan from a 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 day of the grace period. 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; or

c. A change in residence.

You are required to pay premiums for each Insured Person through the date that You notify Us that the Insured Person is no longer eligible or covered, except that if a Dependent is no longer covered because the Dependent becomes enrolled in the children’s basic health plan, established pursuant to Article 8, Title 25.5, CRS, You must notify Us of the change in coverage at least 30 days prior to the date the Dependent will no longer be covered by Us
These changes will be effective on the first of the month following the change, unless as otherwise stated on Your premium notice.

Cigna also reserves the right to change the premium on 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 on the notice, and payment of the new premiums will indicate acceptance of the change.
Cigna will not accept the direct or indirect payment of premiums by any person or entity other than You, Your Family Members or an Acceptable Third Party Payor, except as expressly permitted by Cigna in writing. If Cigna receives any payment of premium in respect of this Agreement directly or indirectly from any source other than You, Your Family Members or an Acceptable Third Party Payor, such payment will be considered a basis for the cancellation of this Policy.

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 under this Policy for the following Year. The Annual Open Enrollment Period is set by the federal government, and the beginning and ending dates are subject to change each Year.

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.

Benefit Period for Hospice Care services is a period of three months, during which services are provided on a regular basis.

Bereavement means that period of time during which survivors mourn a death and experience grief. Bereavement services mean support services to be offered during the bereavement period.

Biologically Based Mental Illness means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, drug and alcohol disorders, (i.e., all substance abuse) dysthymia, syclothymia, social phobia, agoraphobia with panic disorder, general anxiety disorder, and anorexia nervosa and bulimia nervosa

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

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

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

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

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

Coverage Area is any place that is within the counties, cities and/or zip code areas in the state of CO that Cigna has designated as the area where this Plan is available for enrollment

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. 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) which 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. 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.

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 each year before benefits are available under this Policy. Several other types of deductibles apply to this Policy and all are defined in this section

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

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

Diabetes Self-Management Training is instruction, including medical nutrition therapy, 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 and 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;
- that 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;
- and 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 procedure is considered Experimental or Investigational if;

- it has not been demonstrated through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or evaluating the condition or illness for which it is proposed;
- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished and such approval is required by law; or
- the subject of an on-going clinical trial, except as provided in the “Clinical Trials” section of this plan.

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

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

Family Member means Your spouse, children or other persons 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 “Eligibility”

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

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

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

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

Habilitative Services are services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado's EHB benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration." Defining habilitative benefits in this manner provides habilitative benefits on par with those currently offered in rehabilitation and reflects current utilization in the rehabilitative arena.

Home Care Hospice Services are Hospice services, which are provided in the place the Patient designates as his/her primary residence, which may be a private residence, retirement community, or assisted living, nursing or Alzheimer facility.

Home Health Agency means an agency which has been certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal Social Security Act, as amended, for home health agencies and which is engaged in arranging and providing nursing services, home health aide services and other therapeutic and related services.

Home Health Services mean the following services provided by a certified home health agency under a plan of care to eligible persons in their place of residence:

- Professional nursing services.
- Certified and licensed nurse aide services, as defined in section 12-38.1-102(3), C.R.S.
- Medical supplies, equipment and appliances suitable for use in the home.
- Physical therapy, occupational therapy or speech and language therapy services.
- Social Work Practice services, as defined in § 12-43-403,C.R.S., by a licensed social worker, as provided in § 12-43-201(5.5).

Homemaker Services means services provided to the patient which include: general household activities including the preparation of meals and routine household care; and teaching, demonstrating and providing Patient/Family with household management techniques that promote self-care, independent living and good nutrition.

Hospice means a facility or service licensed by the Department of Public Health and Environment under a centrally administrated program of Palliative, supportive and Interdisciplinary Team Services providing physical, psychological, spiritual, and Bereavement care for terminally ill individuals and their families within a continuum of inpatient and Home Care Hospice Service available 24 hours, 7 days a week. Hospice services shall be provided in the home, a licensed Hospice, and/or other licensed health facility. Hospice services include, but are not be limited to the following: nursing services, Physician services, certified nurse aide services, nursing services delegated to other assistants, Homemaker Services, physical therapy, pastoral counseling, trained volunteer services, core services, personal services, hospice day care services and medical social services.

Hospice Care means an alternative way of caring for terminally ill individuals which stresses Palliative care as opposed to curative or restorative care. Hospice care focuses upon the Patient/Family as the unit of care. Supportive services are offered to the family before and after the death of the Patient. Hospice care is not limited to medical intervention, but addresses physical, social, psychological and spiritual needs of the Patient. Hospice care is planned, implemented and evaluated by an Interdisciplinary Team of professionals and volunteers. The emphasis of the Hospice program is keeping the Hospice Patient at home among family and friends as much as possible.

Hospice Levels of Care mean:

- Routine Home Care: the level of care a Patient/Family receives according to the interdisciplinary team's plan of care each day the patient is at home and not receiving Continuous Home Care.
- Continuous Home Care: the level of care received by the patient during a period of medical crisis to achieve palliation and management of acute medical symptoms. The preponderance of care must be nursing care (at least half) and care must be provided for a period of at least eight hours in one calendar day. Home health aide and Homemaker Services, or both, may be provided to supplement nursing care.
- Inpatient Hospice Respite Care: the level of care received when the patient is in a licensed facility to provide the caregiver a period of relief. Inpatient respite care may be provided only on an intermittent, non-routine, short-term basis, limited to periods of five days or less.
- Short-term General Inpatient (acute) Hospice Care: the level of care the patient receives when short-term Inpatient Care for pain control or acute symptom management cannot be achieved in the home. This level of care must be provided in a licensed facility with the approval of the Physician and the Hospice.

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.

Indian Health Program is defined as follows:
The term "Indian Health Program" means—
- any health program administered directly by the Indian Health Service;
- any Tribal Health Program; and
- any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 47 of US Title 25, Chapter 2.

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

Individual Out-of-Pocket Maximum: Once the Individual Out-of-Pocket Maximum has been met for the Year, for Covered Services received from Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Individual 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 as well as amounts such as Copayments, Deductibles, etc., incurred for emergency services from Non-Participating Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

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

Infusion and Injectable Specialty Prescription Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional for rare and/or chronic conditions. These medications include but are not limited to hemophilia factor and supplies, enzyme replacements and Intravenous immunoglobulin. Such specialty medications may require Prior Authorization or precertification, and will only be covered when provided by an approved Participating Provider specifically designated to supply that specialty prescription medication.

Injury means an accidental bodily injury.

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

Interdisciplinary Team means a group of qualified individuals, which shall include, but is not limited to, a Physicians, registered nurses, clergy/counselors, volunteer director and/or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of Hospice Patient/Families.

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
- A percentage of a fee schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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 of charges made by providers of such service or supply in the geographic area where it is received as compiled in 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
- A percentage of a fee schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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

Medically Necessary or Dentally Necessary services or supplies are those that are determined by the Cigna 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.
- 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.

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

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.

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 Policy of treatment)

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

Orthotic Devices are rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part, or to restrict motion in a diseased or injured part of the body.

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 sub-acute facilities.

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.

Palliative Services mean those services and/or interventions which are not curative, but which produce the greatest degree of relief from pain and other symptoms of the Terminal Illness.

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/Family means one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties.

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.

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.

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

Physician is a Physician licensed, or otherwise authorized, 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, and in 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.

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.

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.
- who is engaged in general practice, family practice, internal medicine or pediatrics who, through an agreement with Cigna, provides basic health services to and arranges specialized services for those Insured Persons who select him or her as their Primary Care Physician (PCP).

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.

Reconstructive Surgery is surgery to correct the appearance of abnormal looking features or characteristics of the body caused by birth defects, Injury, medically necessary surgery, congenital hemangioma (port wine stains) on the face and neck of an insured person 18 years and younger, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. Reconstructive Surgery includes surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal craniofacial structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease. Reconstructive Surgery also includes, "breast reconstruction". For the purpose of this Policy, breast reconstruction means reconstruction of a breast incident to mastectomy or lumpectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.

Referral means the approval You must receive from Your PCP in order for the services of a Participating Provider, other than the PCP, or a participating Obstetrician/Gynecologist for medical services to be covered by this Plan. Services for Pediatric Dental Care and Pediatric Vision Care do not require a referral.

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.

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:

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

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

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

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

Specialty Medication means 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.

Substance Abuse means the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment.

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

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.

Tribal Health Program means an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

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

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