Cigna Health and Life Insurance Company may change the premiums of this Policy after 75 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. We will only change premiums on an Annual basis.

Cigna Health and Life Insurance Company ("Cigna")
900 Cottage Grove Road
Bloomfield CT 06002
Cigna Connect 550-3
Individual and Family Major Medical Health 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, Florida 33630-3365
1-877-484-5967

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

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

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Guaranteed Renewable

This Policy is medical coverage subject to continual monthly or quarterly 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. Coverage will end at 12:00 a.m. **Eastern time.**

Renewal: This Policy renews on a Calendar Year basis.

Cancellation by Cigna: 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 a Marketplace or the 90 day grace period for plans purchased from a Marketplace.
2. When You become ineligible for this coverage.
3. If You have committed, any act or practice that constitutes fraud, or made an intentional misrepresentation of material fact in connection with this Policy or coverage.
4. When We cease to offer policies of this type to all individuals in Your class. In this event, Virginia 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.

5. When We cease offering any plans in the individual market in Virginia, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
6. When the Insured no longer resides, lives, or works in the Coverage Area.
7. When Cigna determines that any premium payment for this Policy is being paid directly or indirectly from any source other than You, Your Family Members or an Acceptable Third Party Payor; however, if You, Your Family Members or an Acceptable Third Party Payor make all premium payments for this Policy that are due after the date of Cigna's determination, the Policy shall remain in effect, subject to all other terms and conditions contained herein.

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

Cancellation by You: You may cancel this Policy:

You may cancel Your Policy at any time by written notice delivered or mailed to Cigna. It will be effective upon receipt of notice or on such later date as You may specify in the notice. In the event of cancellation, Cigna will return promptly the unearned portion of any premium paid. The earned premium will be computed pro rata. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

If You become an active-duty member of the military, upon receipt of a written notice of military service We will cancel Your Policy and refund premium on a pro rata basis.

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

Signed for Cigna by:

Matthew G. Manders, President

Anna Krishtul, Corporate Secretary

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

This company is subject to regulation in this Commonwealth of Virginia by both the State Corporation Commission Bureau of Insurance (pursuant to Title 38.2) and the Virginia Department of Health (pursuant to Title 32.1).

In the event You need to contact someone about this insurance for any reason, please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions, You may contact the insurance company issuing this insurance at the following address and telephone number:

Cigna Health and Life Insurance Company ("Cigna")
Individual Services
900 Cottage Grove Road
Bloomfield CT 06002
1.800.Cigna24 (1.800.244.6224)

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1-800-552-7945, in state calls
1-877-310-6560, national toll free number

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your member ID number available.

PAYOR OF LAST RESORT The Department of Medical Assistance Services, which administers Virginia's Medicaid Program, is the payor of last resort. Please note that Cigna will not exclude enrolling an individual or withhold payments for benefits to an Insured or on the Insured's behalf for medical or dental care covered under the Policy because the Insured is eligible for medical assistance under Medicaid.

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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Introduction

About This Policy

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

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

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

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

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

IF, WITHIN 2 YEARS AFTER THE EFFECTIVE DATE OF YOUR PARTICIPATION IN THE POLICY, WE DISCOVER ANY ACT PRACTICE OR OMISSION THAT CONSTITUTES FRAUD, OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED WE MAY RESCIND THIS COVERAGE AS OF THE ORIGINAL EFFECTIVE DATE. ADDITIONALLY, IF WITHIN 2 YEARS AFTER ADDING ADDITIONAL FAMILY MEMBER(S) (EXCLUDING NEWBORN CHILDREN OF THE INSURED ADDED WITHIN 31 DAYS AFTER BIRTH), WE DISCOVER ANY ACT PRACTICE OR OMISSION THAT CONSTITUTES FRAUD, OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED WE MAY RESCIND COVERAGE FOR THE ADDITIONAL FAMILY MEMBER(S) AS OF THE DATE HE OR SHE ORIGINALLY BECAME EFFECTIVE. IF WE RESCIND YOUR COVERAGE, WE WILL PROVIDE YOU WITH 30 DAYS ADVANCE NOTICE AND WE WILL REFUND ALL PREMIUMS YOU PAID FOR YOUR POLICY LESS THE AMOUNT OF ANY CLAIMS PAID BY CIGNA. RESCISSION OF YOUR COVERAGE WILL RESULT IN DENIAL OF ALL PENDING CLAIMS AND, IF CLAIM PAYMENTS 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 AN EXCLUSIVE PROVIDER 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 on **Cigna.com/ifp-providers**, or log onto myCigna.com or call the number on Your ID card to determine if a Provider is In-Network, or to request a printed copy of the Provider Directory be mailed to You.

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 the back of their 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 they 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.

Continuity of Care

If Your PCP or network specialist ceases to be a Participating Physician, except when he or she is terminated from this Plan's network for cause, We will permit that Provider to render health care services for a period of at least 90 days to any Member who:

- Was in an active course of treatment from the Provider prior to the notice of termination; and
- Requests to continue receiving health care services from the Provider.

Also, Cigna will permit any Provider who ceases to be a Participating Physician, except when he or she is terminated from this Plan's network for cause, to continue rendering health services to any Member who

- has entered the second trimester of pregnancy at the time of the Provider's termination of participation. Such treatment shall, at the Member's option, continue through the provision of postpartum care directly related to the delivery; or
- is determined to be terminally ill (as defined under § 1861 (dd)(3)(A) of the Social Security Act) at the time of a Provider's termination of participation. Such treatment shall, at the Member's option, continue for the remainder of the Member's life for care directly related to the treatment of the terminal illness.

We shall reimburse a Provider for continuity of coverage in accordance with the agreement that the Provider had with Us immediately before the Provider's termination of participation.

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, except as indicated below under "Exceptions to the Referral Process". 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:

You can obtain certain services from Participating Providers, and Emergency Services, without a Referral from Your PCP. The following services are excepted from the Referral process:

- Emergency Services

  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 for a Participating Urgent Care facility, but You should, whenever possible, contact Your PCP for direction prior to receiving services.
- If You are a female Insured Person, You may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in "Covered Services and Supplies," without a Referral from Your PCP.
- If You are in Insured Person under age 19, You may 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.
- You do not need a Referral from Your PCP for preventive care services.
- You also do not need a referral from Your PCP for an electronic visit with an Expanded Access Telehealth Provider.

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; and requires specialized medical care over a prolonged period of time, or You are diagnosed with cancer.

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.

A standing referral remains in effect for the duration of the course of treatment. 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, the standing referral then becomes subject to the Continuity of Care provision above. If 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 Maximum Reimbursable 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.

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.

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

Important Information Regarding Benefits

Prior Authorization Program

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

PRIOR AUTHORIZATION FOR INPATIENT SERVICES

Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. Please note: A Participating Provider is responsible for obtaining Prior Authorization and subject to any Penalties for lack of Prior Authorization. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION to a Hospital or certain other facilities 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 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. Please note: A Participating Provider is responsible for obtaining Prior Authorization and subject to any Penalties for lack of Prior Authorization. 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 limitations and exclusions, payment of premium and eligibility at the time care and services are provided.

Retrospective Review

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

PRESCRIPTION DRUG LIST EXCEPTION and PRIOR AUTHORIZATION PROCESS

Prior Authorization or Step Therapy is required for certain Prescription Drugs and Related Supplies. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a Step Therapy determination. Step Therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If Your Physician believes Prescription Drugs or Related Supplies not on Cigna's Drug List are necessary, or wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call, or complete the appropriate Prior Authorization form and fax it to Cigna to request a Prescription Drug List exception or Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician can certify in writing that the Insured Person has previously used a Prescription Drug or Related Supply that is on Cigna's Prescription Drug List or in a Step Therapy Protocol, and the Prescription Drug or Related Supply has been detrimental to the Insured Person's health or has been ineffective in treating the condition and, in the opinion of the prescribing Physician, is likely to again be detrimental to the Insured Person's health or ineffective in treating the condition. The Prior Authorization or Prescription Drug List exception will be reviewed and completed by Cigna within 24 hours of receipt. The Physician should make this request before writing the prescription.

An expedited review may be requested by the prescribing Physician when an Insured Person is suffering from a health condition that may seriously jeopardize the Insured Person's life, health, or ability to regain maximum function or when an Insured Person is undergoing a current course of treatment using a drug not on Cigna's Prescription Drug List. The expedited review will be reviewed and completed by Cigna within 24 hours of receipt. The Physician should make this request before writing the prescription.

If the request is approved, Your Physician will receive confirmation. The Prior Authorization will be processed in Cigna's pharmacy claim system to allow You to have coverage for those Prescription Drugs or Related Supplies. The length of the Prior Authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When Your Physician advises You that coverage for the Prescription Drugs or Related Supplies has been approved, and writes the prescription, You should contact the Pharmacy to fill the prescription(s).

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

If You disagree with a coverage decision, You may appeal that decision in accordance with the provisions of this Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered. Please see the section of this Policy entitled "WHEN YOU HAVE A COMPLAINT OR AN APPEAL" which describes the process for the External Independent Review.

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

BENEFIT SCHEDULE

The following is the Cigna Connect 550-3 Plan Benefit Schedule, including medical, prescription drug and pediatric vision benefits. The Policy sets forth, in more detail, the rights and obligations of both You and Your Family Member(s), and the Plan. It is, therefore, important that all Insured Persons **READ THE ENTIRE POLICY CAREFULLY!**

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

BENEFIT INFORMATION **Note: Covered Services are subject to applicable Annual deductible unless specifically waived.**	**IN-NETWORK PROVIDER** **(Based on the Negotiated Rate)** **YOU PAY**
Medical Benefits	
Annual Plan Deductible **Individual** **Family** **Note:** each person in a Family will not be responsible for more than the Individual amount	**YOU PAY:** **Deductible** $550 $1,100
Co-insurance	**YOU PAY:** You and Your Family Members pay 15% of Charges after the Policy Deductible
Out-of-Pocket Maximum **Individual** **Family** **Note:** each person in a Family will not be responsible for more than the Individual amount	**YOU PAY:** $2,350 $4,700 The following do not accumulate to the Out-of-Pocket Maximum: Penalties and Policy Maximums.

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY
Prior Authorization Program **Prior Authorization – Inpatient Services** **Prior Authorization – Outpatient Services** NOTE: Please refer to the section on Prior Authorization for inpatient and outpatient services for more detailed information. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of your ID card or at www.mycigna.com under "View Medical Benefit Details".	**Your In-Network Provider must obtain approval** for inpatient admissions; **or Your provider may be assessed a penalty** for non-compliance. **Your In-Network Provider must obtain approval** for selected outpatient procedures and services; **or Your provider may be assessed a penalty** for non-compliance.
All Preventive Well Care Services Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details **Note**: Voluntary sterilization for men is covered at the regular plan benefit level.	**YOU PAY:** 0%, Deductible waived
Smoking Cessation **Medical treatment** Maximum of 2 Smoking Cessation Attempts per Year. (includes counseling, see definition of 'Smoking Cessation") (Prescription Drugs for smoking cessation treatment are covered under the Prescription Drug benefit)	**YOU PAY:** 0%, Deductible waived
Early Intervention Program Services *No dollar limits apply *No visit limits for Physical, Occupational or Speech Therapy	**YOU PAY:** Copay or Coinsurance applies for specific benefit provided

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY
Pediatric Vision Care Performed by an Ophthalmologist or Optometrist for Insured Persons less than 19 years of age. (Coverage continues through the end of the month in which the Insured Person turns age 19.) **Please be aware that the Pediatric Vision network is different from the network for Your medical benefits**	**YOU PAY:**
Comprehensive Eye Exam and Refraction for Children Limited to one exam per year	0% per exam Deductible waived
Eyeglasses and Lenses for Children Single Vision, Lined Bifocal, Lined Trifocal, and Lenticular. Limited to one pair per year	0% per pair Deductible waived
Therapeutic Contact Lenses for Children Limited to one pair per year **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	0% per pair Deductible waived
Physician Services	**YOU PAY:**
Office Visit/Home Visit- Primary Care Physician (PCP) Note: PCP required	15%
Retail Health Clinics	15%
TeleHealth Service	**YOU PAY:** Same benefit level as if service was delivered in person
Expanded Access Telehealth Service Electronic visit with an Expanded Access Telehealth Physician Note: if an Expanded Access Telehealth Physician issues a Prescription, that Prescription is subject to all Plan Prescription Drug benefits, limitations and exclusions	**YOU PAY:** 15%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY
Specialist (including consultant, referral and second opinion services) Note: PCP Referral and/or Plan Authorization is required	**YOU PAY:** 15%
Physician Services, continued **Surgery in Physician's office** **Outpatient Professional Fees for Surgery** (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy) **Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy** **In-hospital visits** **Allergy testing and treatment/injections**	**YOU PAY:** 15% 15% 15% 15% 15%
Nutritional Counseling	**YOU PAY:** 15%
Hospital Services **Inpatient Hospital Services** Facility Charges **Professional Charges** **Emergency Admissions**	**YOU PAY:** 15% 15% Benefits are shown in the Emergency Services schedule
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	**YOU PAY:** 15%
Advanced Radiological Imaging (including MRI's, MRA's, CT Scans, PET Scans) Facility and interpretation charges	**YOU PAY:** 15%
All Other Laboratory and Radiology Services Facility and interpretation charges **Physician's Office** **Free-standing Independent lab or x-ray facility** **Outpatient hospital lab or x-ray**	**YOU PAY:** 15% 15% 15%
Rehabilitative Services **Physical and Occupational Therapy** Maximum of 30 visits per Insured Person, per calendar year combined. **Speech Therapy and Speech-language Pathology (SLP) Services** Maximum of 30 visits per Insured Person, per calendar year combined.	**YOU PAY:** 15% 15%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY
Chiropractic Care, Osteopathic Therapy and Spinal Manipulation Treatment Maximum of 30 visits per Insured Person, per calendar year combined. *Physical, occupational and speech therapy limits do not apply when these services are provided as part of the Hospice Care benefit. *Physical, occupational, speech therapy, or cardiac rehabilitation provided in the home will apply to the Home Health Care visit limit instead of the Rehabilitative or Habilitative Therapy Services limits.	15%
Habilitative Services **Physical and Occupational Therapy** Maximum of 30 visits per Insured Person, per calendar year combined. **Speech Therapy and Speech-language Pathology (SLP) Services** Maximum of 30 visits per Insured Person, per calendar year combined. **Chiropractic Care, Osteopathic Therapy and Spinal Manipulation Treatment** Maximum of 30 visits per Insured Person, per calendar year combined. *Physical, occupational and speech therapy limits do not apply when these services are provided as part of the Hospice Care benefit. *Physical, occupational, speech therapy, or cardiac rehabilitation provided in the home will apply to the Home Health Care visit limit instead of the Rehabilitative or Habilitative Therapy Services limits.	**YOU PAY:** 15% 15% 15%
Cardiac & Pulmonary Rehabilitation Physical, occupational, speech therapy, or cardiac rehabilitation provided in the home will apply to the Home Health Care visit limit instead of the Rehabilitative or Habilitative Therapy Services limits.	**YOU PAY:** 15%
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	**YOU PAY:** 15%
Women's Contraceptive Services, Family Planning and Sterilization	**YOU PAY:** $0, Deductible waived
Male Sterilization	**YOU PAY:** 15%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY
Maternity (Pregnancy and Delivery) /Complications of Pregnancy **Initial Office Visit to confirm pregnancy** and subsequent prenatal visits billed separately from the "global" fee **Prenatal services, Postnatal and Delivery** (billed as "global" fee) **Hospital Delivery charges** **Prenatal testing or treatment** billed separately from "global" fee **Postnatal visit or treatment** billed separately from "global" fee	**YOU PAY:** 15% 15% 15% 15% 15%
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 100 days per stay.	**YOU PAY:** 15%
Home Health Services Maximum 100 visits maximum per Insured Person, per calendar year. Maximum 16 hours per day Maximum 8 visits per day **Note:** Private Duty Nursing is limited to 16 hours per year.	**YOU PAY:** 15%
Durable Medical Equipment	**YOU PAY:** 15%
Prosthetics and Orthotics	**YOU PAY:** 15%
Hospice In-home Inpatient Outpatient	**YOU PAY:** 15% 15% 15%
Dialysis In-home Inpatient Outpatient	**YOU PAY:** 15% 15% 15%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate) YOU PAY
Mental, Emotional or Functional Nervous Disorders **Inpatient** (Includes Acute and Residential Treatment and partial hospitalization) **Outpatient** (Includes individual, group, intensive outpatient therapy) **Office Visits** **All other outpatient services**	**YOU PAY:** 15% 15% 15%
Substance Use Disorder **Inpatient Detoxification/Rehabilitation** (Includes Acute and Residential Treatment and partial hospitalization) **Outpatient** (Includes individual, group, intensive outpatient therapy) **Office Visits** **All other outpatient services**	**YOU PAY:** 15% 15% 15%
Organ and Tissue Transplants- (see benefit detail in "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.) **Cigna LIFESOURCE Transplant Network® Facility** **Travel Benefit,** (Only available through Cigna Lifesource Transplant Network ® Facility) Note: Travel benefit maximum payment of $10,000 per transplant **Other Cigna Network Facility**	**YOU PAY:** 0% 0% 15%
Infusion and Injectable Specialty Prescription Medications and related services or supplies administered by a medical professional in an office or outpatient facility	**YOU PAY:** 15%
Dental Care (other than Pediatric) Limited to treatment for accidental injury to natural teeth within 12 months of the accidental injury	**YOU PAY:** 15%

Emergency Services **(Note: This Plan covers Emergency Services from In- and Out-of-Network Providers as shown:**	**What You Pay For Participating Providers based on the Cigna Negotiated Rate**	**What You Pay For Non-Participating Providers based on the Maximum Reimbursable Amount**
Emergency Services	**You Pay**	**You Pay:**
Hospital Emergency Room	15%	In-network benefit level for an Emergency Medical Condition only, otherwise Not Covered (You pay 100% of charges)
Urgent Care Services	15%	In-network benefit level for an Emergency Medical Condition only, otherwise Not Covered (You pay 100% of charges)
Ambulance Services **Note:** coverage for Medically Necessary transport to the nearest facility capable of handling an Emergency Medical Condition.		
Emergency Transport	15% for Ground, Air and Water transport	In-network benefit level for an Emergency Medical Condition only, otherwise Not Covered (You pay 100% of charges)
Non-Emergency Transport	Not Covered (You pay 100% of charges)	Not Covered (You pay 100% of charges)
Inpatient Hospital Services (for emergency admission to an acute care Hospital)		
Hospital Facility Charges Emergency Services from an Out-of-Network Provider are covered at the In-Network benefit level until the patient is transferrable to an In-Network facility. Out-of-Network facility benefits are not covered once the patient can be transferred, whether or not the transfer takes place.	15%	In-Network benefit level until transferable to an In-Network Hospital; if not transferred then Not Covered (You pay 100% of charges)
Professional Services	15%	In-Network benefit level until transferable to an In-Network Hospital; if not transferred then Not Covered (You pay 100% of charges)

BENEFIT INFORMATION	RETAIL PHARMACY Preferred Pharmacy and Network Pharmacy YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
In the event that You request a Brand Name drug that has a Generic equivalent, You will be financially responsible for the amount by which the cost of the Brand Name drug exceeds the cost of the Generic drug, plus the Generic Copay or Coinsurance shown in this Benefit Schedule.		
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 Up to a 90 day maximum supply	15%	15%
Tier 2: Non-Preferred Generic Up to a 90 day maximum supply	15%	15%
Tier 3: Preferred Brand Up to a 90 day maximum supply	15%	15%
Tier 4: Non-Preferred Brand Up to a 90 day maximum supply	50%	50%
Tier 5: Specialty Up to a 30 day maximum supply	40% Deductible waived	30% Deductible waived
Preventive Drugs regardless of Tier (including women's contraceptives) that are: •Prescribed by a Physician •Generic or Brand Name with no Generic alternative) (including smoking cessation products)	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.

Definitions

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

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

1. the Ryan White HIV/AIDS Program established under Title XXXVI of the Public Health Service Act;
2. an Indian tribe, tribal organization, or urban Indian organization;
3. a State or Federal government program; or
4. an independent private entity that (i) is organized as a not-for-profit organization under State law, (ii) has received a determination from the Internal Revenue Service that the entity qualifies for an exemption from federal income tax under 26 U.S.C. § 501(c)(3), and (iii) makes payments on Your behalf solely on the basis of Your financial need and does not in any way consider the health status of any Insured Person in determining whether to make such payments on Your behalf.

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

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

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 Virginia that Cigna has designated as the area where this Plan is available for enrollment. The Coverage Area includes the following counties; Amelia, Charles City, Chesterfield, Dinwiddie, Hanover, Henrico, Prince George, Sussex, Colonial Heights City, Hopewell City, Petersburg City, Richmond City, Alexandria City, Arlington, Clarke, Fairfax City, Fairfax, Falls Church City, Loudoun, Manassas City, Manassas Park City, Prince William, Stafford, and Warren.

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. 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.

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

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

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

Diabetes Pharmaceuticals & Supplies include, but are not limited to, test strips for blood glucose monitors; visual reading and urine test strips; tablets which test for glucose, ketones and protein; blood glucose monitors on Cigna's Prescription Drug List; lancets and lancet devices; insulin and insulin analogs, injection aids; including devices used to assist with insulin injection and needle less systems; syringes and needles,

biohazard disposal containers, prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits .

Domestic Partner means a person of the same or opposite sex for whom all of the following are true:
- he or she is the Policyholder's sole domestic partner and has been for twelve (12) months or more;
- he or she is mentally competent;
- neither the Policyholder nor the domestic partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under *state* law;
- he or she is not married to or separated from anyone else; and
- he or she is financially interdependent with the Policyholder.

Durable Medical Equipment is defined as items which:

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

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

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

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

- placing serious jeopardy to the mental or physical health of the individual; or
- 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; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:
(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; or
- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows it is the subject of ongoing phase I, II or III clinical trials or understudy to determine if maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the state or means of treatment or diagnosis;
- or reliable evidence shows that the consensus of the opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the stated means of treatment of diagnosis.

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

Family 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 Pocket Maximum and will always be paid by You. The amount of the Family Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

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

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

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

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

Hospital means an institution that:

- Is operated pursuant to law and licensed as a hospital,
- Is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
- Provides 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.).

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 or convalescent homes, convalescent facilities, rest facilities, nursing facilities, or homes or facilities

primarily for the aged, drug addicts, alcoholics and those primarily affording Custodial Care, educational care or those primarily affording care for mental and nervous disorders.

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

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

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.

Marketplace, with respect to Virginia, means the federally-facilitated Marketplace.

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 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.

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 Covered Services and supplies are those determined by the Cigna Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

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.

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 plan of treatment)

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

Orthotics are certain types of braces, boots, splints. That are custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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.

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

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

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

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

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

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

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

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

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

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

Policy Year is defined as a 12-month period that begins each January 1 at 12:01 a.m. Eastern Time.

Note: Deductible and other benefit accumulations accumulate on a Calendar Year rather than Policy Year basis.

Prescription Drug is

- a drug which has been approved by the Food and Drug Administration for safety and efficacy;
- certain drugs approved under the Drug Efficacy Study Implementation review; or

- drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

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

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

Primary Care Physician is a Physician: 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 artificial substitutes to replace, in whole or in part, a limb or body part, such as an arm, leg, foot or eye.

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, 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 to be covered, as stated under "Referrals" and "Exceptions to the Referral Process" in the "Introduction" section of this Policy.

Rehabilitation Services include a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, medical devices, and services of a social

worker or psychologist. Services are provided in a Hospital, free-standing facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

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 Cigna.com/ifp-providers or log onto www.mycigna.com and click on "find a Doctor, Dentist or Facility".

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

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

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

Smoking Cessation Attempt means four 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.

Special Limits are limits applied to certain Covered Expenses in the form of a per visit, per day, or per event maximum. We will only apply the Special Limit amount to any Deductible, Even when an Out-of-Pocket Maximum is reached, We will still apply the Special Limits to the applicable Covered Expenses. The expenses You incur which exceed specific maximums described in this Policy will be Your responsibility. The Special Limits are described in the Benefit Schedule and in the section of this Policy titled "How The Policy Works"

Specialty Medication means a Generic Prescription Drug 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 a small molecule drug (organic compound, binds to a protein, nucleic acid, or polysaccharide); AND

B. In general meets at least THREE (3) of the following attributes:
   - Targets the underlying disease pathology;
   - Modifies disease sequel;
   - Targets conditions that are rare, chronic, and costly;

C. Requires close supervision and monitoring of therapy for safety and effectiveness;
D. 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, or with respect to a pregnant woman, that the woman has delivered, including the placenta.

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.

Telehealth/Telemedicine Medical Service as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment.

Terminal Illness means the Insured Person has a medical prognosis that his or her life expectancy is 6 months or less.

Urgent Health Problem means a medical condition that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person’s life.

Urgent Care means Covered Services that (i) are delivered at an outpatient or other sub-acute facility that is accredited as an urgent care center by the Urgent Care Association of America or by the National Urgent Care Center Accreditation program and (ii) are provided to treat an Urgent Health Problem.

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

Who Is Eligible For Coverage?

Eligibility Requirements

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

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

- You are a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and are reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought; and
- You are a resident of the state of Virginia; and
- You live in the Coverage Area in which You are applying, and intend to continue living there for the entire period for which enrollment is sought; and
- You are not incarcerated other than incarceration pending the disposition of charges; and
- 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):

NOTE: a Dependent Spouse, Domestic Partner or a Dependent child must reside in the Service Area, unless the child is covered under a Qualified Medical Child Support Order and lives outside the Service Area. A child eligible to enroll as a Dependent under this Agreement who resides outside of the Service Area is entitled to receive, while outside the Service Area, only out-of-area emergency benefits under the “Emergency Services” provision of the “Services and Benefits” section. However, that child, when he or she is within the Service Area, is eligible for benefits for Covered Services from In-Network Providers, as outlined in this Policy.

- Your lawful spouse or Domestic Partner who lives in the Coverage Area.
- Your children or anyone who is dependent on You who live in the Coverage Area and have not yet reached age 26.
- Your stepchildren who live in the Coverage Area and have not yet reached age 26.
- Your own, or Your lawful spouse's or Domestic Partner’s unmarried children, regardless of age, enrolled prior to age 26, who are incapable of self-support due to medically certified continuing intellectual or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's or Domestic Partner’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. This also applies to a newborn child with respect to whom:
  - a decree of adoption by You has been entered within 31 days after the date of the child’s birth; or
  - adoption proceedings have been instituted by You within 31 days after the date of the child’s birth and You have temporary custody; or

- the adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child.
- An adopted child is eligible for coverage from the date of adoption or parental placement with an Insured Person, and if the adoption occurred within 31 days of birth, the child shall be considered a newborn child of the Insured Person as of the date of placement. This shall continue unless the placement is disrupted prior to final decree of adoption or the child is removed from placement.

- An adopted child, including a child who is placed with You for adoption, is automatically covered for 31 days from the date of the adopted child's placement for 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 or initiation of a suit of adoption.
- A child who is placed with You for foster care is automatically covered for 31 days from the date of the foster child's placement. To continue coverage past that time You must enroll the foster child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date the child is placed with You for foster care, and pay any additional premium. Coverage for a foster child enrolled within 61 days of placement for foster care will be retroactive to the date of the child's placement for foster care.
- 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. If a court has ordered an Insured to obtain coverage for a child, and that parent fails to obtain coverage as ordered, the child's other parent or the Virginia Department of Social Services may enroll the child for coverage as a dependent of the Insured.

When Can I Apply?

Application to Enroll or Change Coverage

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

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

Annual Open Enrollment Period

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

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

Your coverage under this Policy will then become effective upon the earliest day allowable under federal rules for that Year's open enrollment period. **Note: If You do not apply to obtain or change coverage**

during the Annual Open Enrollment Period, You will not be able to apply again until the following Year's Annual Open Enrollment Period unless You qualify for a special enrollment period as described below.

Special Enrollment Periods

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

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

Triggering events for a special enrollment period are:

- An eligible individual, and any dependent(s), loses his or her minimum essential coverage; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gaining or becoming a dependent through marriage, birth, adoption or placement for adoption, placement in foster care, or through a court order; or
- An eligible dependent spouse, Domestic Partner or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An 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 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 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; or
- 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 have coverage effective dates determined as follows):

- In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care;
- In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, coverage is effective for a qualified individual or enrollee on the first day of the following month.

For all other triggering events the effective dates are:

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

Specific Causes for Ineligibility

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

- When premiums are not paid according to the due dates and grace periods described in the premium section.
- For the spouse - when the spouse is no longer married to the Insured.
- For the Domestic Partner, when the domestic partnership is dissolved or otherwise ceases to exist.
- For You and Your Family Member(s) when You no longer meet the requirements listed in the Eligibility Requirements section;
- The date the Policy terminates.
- When the Policyholder no longer resides, lives, or works in the Coverage 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.

Continuation

If a spouse or domestic partner's eligibility under this Plan would terminate due to the Insured's death, except for the Insured's failure to pay premium, that spouse or domestic partner has the right to continuation of his or her insurance. Coverage will be continued under the spouse or domestic partner's name. In such a case, coverage will continue without evidence of insurability.

If an Insured Person's eligibility under this Plan would terminate due to divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, that Family Member has the right to continuation of

his or her insurance. Coverage will be continued under that Member's name if the Family Member exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Agreement would otherwise terminate. In such a case, coverage will continue without evidence of insurability.

How The Policy Works

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

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

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

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.

Benefit Schedule

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

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

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.

- **Specialty care not available from an In-Network Provider**
  When Medically Necessary specialist care is not available from an In-Network Provider Covered Expense for Covered Services will be paid at the Participating Provider benefit schedule.

- **Facility Services for an Urgent Health Problem**
  Services for an Urgent Health Problem in an office, Urgent Care facility or other outpatient facility will be paid at the Participating Provider benefit schedule until the patient is stabilized and his/her condition permits release to home or transfer to a Participating facility, services of a Non-Participating facility will no longer be covered.

- **Physician or other provider Services for an Urgent Health Problem**
  Covered Expense will be paid at the Participating Provider benefit schedule for the initial care of an Urgent Health Problem.

Note: Charges for Non-Participating Providers are reimbursed at the Maximum Reimbursable Charge as defined in this Policy. If the Non-Participating Provider charges exceed the Maximum Reimbursable Charge allowed for the service You received, You will be responsible to pay the Provider any amount in excess of the Maximum Reimbursable Charge.

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, any penalties, or expenses that are not Covered Expenses.

Deductibles will be applied in the order in which an Insured Persons claims are received and processed by Us, not necessarily in the order in which the Insured Person 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 Maximum is the amount of Coinsurance, Deductible, and Copayment each Insured Person incurs for Covered Expenses in a Year. The Out-of-Pocket Maximum **does 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 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. Each Insured Person can contribute up to the Individual Out-of-Pocket

amount 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.

Special Limits

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

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

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

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

Penalties will apply under the following circumstances:

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

Penalties are applied before any benefits are available.

Comprehensive Benefits: What the Policy Pays For

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

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

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

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

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

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

- Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
- 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.

Services and Supplies Provided by a Skilled Nursing Facility

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

This Policy provides benefits for Inpatient Skilled Nursing and related services for convalescent and rehabilitative care, Covered Services are available if the facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service. The following items and services will be provided to You as inpatient in a skilled nursing facility:

- room and board in semi-private accommodations;
- rehabilitative services; and
- drugs, biologicals, and supplies furnished for use in the Skilled Nursing Facility and other Medically Necessary services and supplies.

This Policy provides benefits for the Covered Expenses for the private room charge if You need a private room because You have a highly contagious condition or are at greater risk of contracting an infectious disease because of Your medical condition. Otherwise, Your inpatient benefits would cover the Skilled Nursing Facility's charges for a semi private room. If You choose to occupy a private room, You will be responsible for paying the daily differences between the semi-private and private room rates in addition to Your copayment and coinsurance (if any).

Note: No benefits will be provided for:

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

Hospice Services

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

To be eligible for this benefit, the provider must be appropriately licensed according to state and local laws to provide Skilled Nursing and other services to support and care for persons experiencing the final phases of Terminal Illness. The provider must also be approved as a Hospice provider under Medicare and the Joint Commission on Accreditation of Health Care Organizations or by the appropriate agency of the state in which this Policy is sold.

The services and supplies listed below are Covered Services when provided by a Hospice for the palliative care of pain and other symptoms that are part of a Terminal Illness. For the purposes of this benefit palliative care means care that controls pain and relieves symptoms, but is not meant to cure a Terminal Illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Coverage includes short-term inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. For the purposes of this benefit respite care means non-acute inpatient care for the Insured Person in order to provide the Insured Person's primary caregiver a temporary break from caregiving responsibilities.
- Skilled Nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse. Social services and counseling services from a licensed social worker. Nutritional support such as intravenous feeding and feeding tubes. Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.

- Pharmaceuticals, medical equipment, and supplies needed for pain management and the palliative care of the Insured Person's condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Insured Person's death. Bereavement services are available to surviving members of the immediate family for one year after the Insured Person's death. For the purposes of this benefit immediate family means all Family Members covered by this Policy.

The Insured Person's Physician and Hospice medical director must certify that the Insured Person is Terminally Ill and likely has less than six months to live. The Insured Person's Physician must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to Us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to an Insured Person in Hospice. These additional Covered Services will be covered under other parts of this Policy

Professional and Other Services

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

This Policy provides benefits for Covered Expenses incurred for:

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

Surgery

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

This Policy provides benefits for surgical services on an Inpatient and outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Surgeries and procedures to correct congenital abnormalities that cause functional impairment and congenital abnormalities in newborn children;

- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

Reconstructive Surgery

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

This Policy provides benefits for Reconstructive Surgery to correct significant deformities caused by congenital or developmental abnormalities, Illness, injury or an earlier treatment in order to create a more normal appearance. Covered Services include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Policy.

Note: This section does not apply to orthognathic surgery. See the "Oral Surgery" section for that benefit.

Mastectomy Notice

An Insured Person having Reconstructive services for a mastectomy or for follow-up care for a mastectomy and chooses breast reconstruction will also be covered for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Services will be covered as any other medical service under this Policy.

Diagnostic Services

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

This Policy provides benefits for tests or procedures to find or check a condition when specific symptoms exist, as well as benefits for interpretation of diagnostic tests such as imaging, pathology reports, and cardiology. Tests must be ordered by a Physician and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Radiology (including mammograms), ultrasound or nuclear medicine
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance spectroscopy (MRS)

- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography
- Single photon emission computed tomography (SPCECT) scans

The list of advanced imaging services may change as medical technologies change.

Note: Services may require Prior Authorization.

Radiation Therapy

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

This Policy provides benefits for the treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration, and treatment planning.

Respiratory Therapy

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

This Policy provides benefits for the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho pulmonary drainage and breathing exercises.

Infusion Therapy

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

This Policy provides benefits for nursing, Durable Medical Equipment and drug services that are delivered and administered to You through an I.V. in Your home. Services also include total parenteral nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. Services may include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section “Prescription Drugs and Specialty Medication Covered as Medical” for more details.

Dialysis

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

This Policy provides benefits for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis facility or doctor’s office Covered Services also include home dialysis and training for You and the person who will help You with home self-dialysis.

Durable Medical Equipment

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

This Policy provides benefits for Durable Medical Equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Physician.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by Cigna. Cigna may limit the amount of coverage for ongoing rental of equipment. Cigna may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

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

Cigna determines whether the item meets these conditions and whether the equipment falls under a rental or purchase category. Insured Persons can appeal Cigna's determination. Please see the section of the Policy titled "When You Have a Complaint or an Appeal".

Prosthetic Appliances and Devices

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

This Plan also includes benefits for prosthetics and components when they are Medically Necessary for activities of daily living. A prosthetic device is an artificial substitute to replace, in whole or in part, a limb or body part, such as an arm, leg, foot or eye. Coverage is also included for the repair, fitting, adjustments and replacement of a prosthetic device. In additional, components for artificial limbs are covered. Components are the materials and equipment needed to ensure the comfort and functioning of the prosthetic device.

Covered Services may include, but are not limited to:

1) Artificial limbs and components (the materials and equipment needed to ensure the comfort and functioning of the prosthetic device);

2) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.

3) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.

4) Restoration prosthesis (composite facial prosthesis)

5) Wigs needed after cancer treatment.

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.

Orthotics

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

This Policy provides benefits for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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, air or water 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 for emergency situations, to the nearest facility capable of handling the emergency or Medically Necessary transfers from one medical facility to another only.

When We are presented with an assignment of benefits from a provider of ambulance services We will provide reimbursement of benefits directly to the provider of services.

Habilitative and Rehabilitative Services

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

This Policy provides benefits for the therapy services described below. These Covered Services are defined in the Definitions section of this Policy under 'Rehabilitation Services' and 'Habilitative Services'. Covered Services include:

Physical therapy – Is the treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.

Speech therapy and speech-language pathology (SLP) services – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.

Occupational therapy – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.

Chiropractic / Osteopathic / Manipulation therapy – Is therapy which Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Services for Cardiac and Pulmonary Rehabilitation

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

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

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

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

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

This Policy provides benefits for the following:

Inpatient Services Coverage includes individual psychotherapy, group psychotherapy, psychological testing, and counseling with Family Member's to assist with the patient's diagnosis and treatment, and convulsive therapy, detoxification, and rehabilitation treatment; hospital and inpatient professional charges in any hospital or facility required by state law.

Outpatient Services Coverage includes diagnosis and treatment of psychiatric conditions, individual and group psychotherapy, psychological testing, office visits, outpatient facility and physician charges, and medication management checks.

Partial Hospitalization or Partial Day Services includes services provided by a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

Residential Treatment for mental health and substance use disorders that is provided in a hospital or treatment facility licensed to provide a continuous, structured program of treatment and rehabilitation, including 24 hour-a-day nursing care. Individualized and intensive treatment includes observation and assessment by a psychiatrist at least weekly and rehabilitation, therapy, education, and recreational or social activities.

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, professional and facility services for childbirth including use of the delivery room, and care for normal deliveries, in a facility or the home including the services of an appropriately licensed nurse midwife.

All comprehensive benefits described in this Plan are available for maternity services. Comprehensive Hospital benefits for routine nursery care of a newborn child are available so long as the child qualifies as an Eligible Dependent as defined in 'Conditions of Eligibility' in the section of this Plan titled "Who is Eligible for Coverage?".

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

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

We will not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization for prescribing a length of stay that does not exceed the above periods. However, 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.

Charges for breastfeeding supplies including one breast pump per pregnancy, support and counseling are covered without copays/coinsurance, or deductibles for the duration of breastfeeding. Such services will be consistent with protocols and guidelines developed by attending providers or by national pediatric, obstetric and nursing professional organizations for these services and shall be provided by qualified health care personnel trained in postpartum maternal and newborn pediatric care.

Postnatal services for the baby include hemoglobinopathies screening; gonorrhea prophylactic medication; hypothyroidism screening, PKY screening and Rh incompatibility testing; and fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by Us.

Benefits are also provided for a newborn home visit or visits which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

This Policy includes benefits for a pregnancy following an act of rape of an Insured Person which was reported to the police within seven days following its occurrence, to the same extent as any other covered pregnancy. The 7-day requirement shall be extended to 180 days in the case of an act of rape or incest of a female Insure Person under 13 years of age.

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

This Policy provides benefits for Covered Expenses including services to diagnose and treat conditions resulting in infertility. Please note: treatment for Infertility, such as in vitro fertilization and other types of artificial or surgical means of conception and associated procedures and the related medications are not covered.

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

This Policy provides benefits for laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy. Coverage includes benefits for a minimum stay in the hospital of not less than 23 hours for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy, as outlined in Milliman and Robertson's nationally recognized guidelines. A shorter stay is acceptable provided the attending Physician, in consultation with the Insured Person, determines that a shorter hospital stay is appropriate.

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 at no cost share. Payment will be provided for Covered Expenses for preventive care services including the following:

- Routine physical exams.
- Annual mammogram, Pap test and PSA.
- 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;
- Flu Shots (including administration)
- 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
- Coverage will be provided for newborn hearing screenings and all audiological examinations ordered by the attending Physician. This includes follow-up audiological exams recommended by the Physician to confirm hearing loss.
- For women, such additional preventive care and screenings, including contraceptive methods and voluntary sterilization treatments, 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, (except for anti-malaria), employment, school or sports.

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

Payment will be provided for Covered Expenses for the following preventive health care services:

- Obstetrical and gynecological services that are provided by qualified Providers for care of or related to the female reproductive system and breasts, and for annual screening, counseling and immunizations for disorders and diseases in accordance with the most current recommendations of the American College of Obstetricians and Gynecologists. Gynecological services include coverage for cervical cancer screening and surveillance tests for ovarian cancer.
- Cervical cancer screening includes examinations and laboratory tests for the early detection of cervical cancer. Examinations and laboratory tests means conventional Pap smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis have been approved by the United States Food and Drug administration. Surveillance tests are for women at risk for ovarian cancer. “At risk for ovarian cancer” means either:
  - having a family history with at least one first-degree relative with ovarian cancer; and a second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or
  - testing positive for a hereditary ovarian cancer syndrome.

  For the purposes of this benefit “Surveillance tests” mean annual screening using transvaginal ultrasound and rectovaginal pelvic examination
- Charges for mammograms, including: (a) a baseline mammogram (b) a mammogram every other year (c) or a mammogram every year if Medically Necessary and (d) the Physician's interpretation of the laboratory results. Mammograms may be done more frequently if recommended by a Physician because the woman has a personal history of breast cancer or biopsy-proven benign breast disease; a female family member has had breast cancer or the woman has not given birth before the age of 30.
- Prostate Specific Antigen (PSA) tests or equivalent tests for the presence of prostate cancer, and the Office Visit and physical examination associated with this test when ordered by the Insured Person’s Physician or nurse practitioner. For the purpose of this section, “PSA testing” means the analysis of a blood sample to determine the level of prostate specific antigen
- Charges for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, shall be provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

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 postgenetic testing.

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

This Policy provides coverage for Medically Necessary early intervention services; such as speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents who are certified by the Department of Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Behavioral Health and Developmental Services shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure. This benefit is not subject to any dollar limits. Physical, occupational and speech therapy provided as part of early intervention services are not subject to short term rehabilitation visit limits.

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

Circumcision of a male Insured Person is covered the same as any other medical benefit.

Congenital Defects and Birth Abnormalities for Newborns
(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Covered Expenses for the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities for newborns.

Benefits include but are not limited to inpatient and outpatient dental, oral surgical, and orthodontic services that are Medically Necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia.

Diagnosis and Treatment of Lymphedema
(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

Charges for the diagnosis, evaluation and treatment of lymphedema and are paid on the same basis as any other medical condition. Coverage will include benefits for equipment, supplies, complex decongestive therapy, gradient compression garments, which require a prescription and are custom-fit for the Insured, self-management training and education, if the treatment is determined to be Medically Necessary and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice.

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").

This Policy provides benefits for Hospital and professional services as described in the 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 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 reimbursement of $10,000 per lifetime, as shown in the Plan Benefit Schedule.

Cigna LIFESOURCE Transplant Network® Facility Benefit Exclusions and Limitations should this also include non-Lifesource providers

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 per 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 determined 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.

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

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

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

Insulin; 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.

Treatment Received from Foreign Country Providers
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

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

Cigna does not accept assignment of benefits from Foreign Country Providers. You and Your Family Member can file a claim with Cigna for services and supplies from a Foreign Country Provider but any payment will be sent to the Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. The Insured Person at their expense is responsible for obtaining an English language translation of Foreign Country Provider claims and any medical records that may be required. Benefits are subject to all terms, conditions, limitations, penalties, 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.

Telehealth/Telemedicine Medical Services
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

Services for Telehealth/Telemedicine are covered under this Policy on the same basis as any other medical benefit. Please refer the “Definitions” section of this Policy for a complete description of the services.

Note: this benefit does not include Expanded Access Telehealth Service.

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 myCigna.com, then go to Find a Doctor page, and then click on Cigna Telehealth Connection.

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.

Home Health Care

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

Services must be furnished by a Home Health Agency or a Visiting Nurses Association.

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

Home Health Care Services must be provided by one of the following providers:

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

Private duty nursing services and nutritional counseling are covered, if provided as part of a home health care treatment program.

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

This Policy provides benefits for Covered Expenses for Smoking Cessation Attempts, as defined in the Policy, up to the maximum as shown in the Benefit Schedule. Tobacco cessation products, including nicotine patches and gum when obtained with a prescription, are covered under Preventive Care with no cost sharing.

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 not less than 48 hours following a radical or modified radical mastectomy and not less than 24 hours following a total mastectomy or a partial mastectomy with 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.

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 12 months following the date of Injury;
- Dental appliances required to diagnose or treat an accidental injury to the teeth, and the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face, are also covered.
- damage to natural teeth due to chewing or biting is not considered an accidental Injury under this Policy.

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

This Policy provides benefits for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants.
Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Hospitalization and Anesthesia for Dental Procedures
(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

Benefits are payable for general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care by a licensed dentist in consultation with a physician to require general anesthesia and admission to a hospital or outpatient surgery facility to safely and effectively provide dental care for:

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

We may require Prior Authorization.

Treatment for Temporomandibular Joint Dysfunction (TMJ) and Craniomandibular Disorders
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Covered Expenses to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Procedures Involving Bones and Joints of The Head, Neck, Face or Jaw
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Covered Expenses for diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw. If treatment is required because of a medical condition or injury which prevents normal functions of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part.

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

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.
Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Maxillary or mandibular frenectomy when not related to a dental procedure.
- Alveolectomy when related to tooth extraction.
- Orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the “Dental Services (All Members / All Ages)” section.
- Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.

- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Nutritional Formulas: Amino Acid-Based Elemental Formula or organic acid metabolism, metabolic abnormality or severe protein or soy allergies

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

This Policy provides benefits for Covered Expenses made for amino acid-based elemental formulas or organic acid metabolism, metabolic abnormality or severe protein or soy allergies, and the services associated with administration of the formulas when prescribed by the treating physician, regardless of the formula delivery method, that are used for the diagnosis and treatment of:

- immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- severe food protein-induced enterocolitis syndrome;
- eosinophilic disorders, as evidenced by the results of a biopsy; and
- impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Amino acid based elemental formulas may be reviewed for Medical Necessity.

Sleep Testing and Treatment

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

This Policy provides benefits for Covered Expenses for devices, supplies and diagnostic treatments made or ordered by a Physician for diagnostic sleep tests and for sleep treatments. This Policy includes coverage for devices and supplies, such as APAP, CPAP, BPAP and oral devices for sleep treatment. These services are subject to Medical Necessity.

Clinical Trials

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

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

(1) is eligible to participate in an approved clinical trial according to the trial protocol with respect to the prevention, detection and treatment of cancer or other life threatening disease or condition and

(2) Either

(A) the referring health care professional is a participating health care provider and has concluded that the Insured Person's participation in such trial would be appropriate based upon the Insured Person meeting the conditions described in paragraph (1); or

(B) the Insured Person provides medical and scientific information establishing that the Insured Person's participation in such trial would be appropriate based upon the Insured Person meeting the conditions described in paragraph (1)

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

The clinical trial must meet 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; or
3. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Hemophilia and Congenital Bleeding Disorder
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

Benefits for Covered Expenses will be provided for services incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. The benefits include coverage for the purchase of blood products, include, but are not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate, and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.

Drugs Used in Treatment of Cancer

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

Benefits for Covered Expenses will be provided for charges for a drug that has been prescribed for the treatment of a type of cancer for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be covered, provided: (a) it is recognized for the treatment of the specific type of cancer for which the drug has been prescribed in one of the following reference compendia: the National Comprehensive Cancer Network's Drugs & Biologics Compendium, the Elsevier Gold Standard's Clinical Pharmacology, the United States Pharmacopeia Drug Information; the American Medical Association Drug Evaluations; the American Hospital Formulary Service Drug Information; or the drug is recommended by one review article in a U.S. peer-reviewed national professional journal; (b) it has been otherwise approved by the FDA; and (c) its use for the specific type of cancer treatment prescribed has not been contraindicated by the FDA.

Orally Administered Anticancer Medications

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

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

Payment to Virginia Department of Medical Assistance Services

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

This Plan will directly reimburse the Virginia Department of Medical Assistance Services for Covered Services to the extent that the Department has paid for such services, upon receipt of verification of payment for such services from the Department.

Exclusions And Limitations: What Is Not Covered By This Policy

Excluded Services

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

- **Services obtained from an Out-of-Network (Non-Participating) Provider**, except for Emergency Services (including Emergency Services provided by an Urgent Care facility), and specialty care, in the event that Medically Necessary specialist services are not available from an In-network Provider.
- 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 are considered to be for **Experimental Procedures or Investigative Procedures,** except as otherwise stated in this Policy under 'Clinical Trials'.
- Services **received before the Effective Date of coverage**.
- Services **received after coverage under this Policy ends**.
- Services **for which You have no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, **under any workers' compensation, employer's liability law or occupational disease law**, except coverage for any medical condition pursuant to such exclusion if (i) an award of the Workers' Compensation Commission denies compensation benefits relating to such medical condition and no request for review of such award is made pursuant to and within the time prescribed by applicable law; or (ii) an award of the Workers' Compensation Commission, after review by the full Commission, denies compensation benefits relating to such medical condition. Following the entry of a workers' compensation award pursuant to clause (i) or (ii) having the effect of prohibiting the application of any such exclusion, Cigna shall immediately provide coverage for such medical condition to the extent otherwise covered under the contract, subscription contract or health services plan. If, upon appeal to the Court of Appeals or the Supreme Court, such medical condition is held to be compensable under the Virginia Workers' Compensation Act (Title 65.2), Cigna may recover from the applicable employer or workers' compensation insurance carrier the costs of coverage for medical conditions found to be compensable under the Act.
- Conditions caused by: (a) an **act of war (declared or undeclared)**; (b) the **inadvertent release of nuclear energy** when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person **participating in the military service of any country**; (d) an Insured Person **participating in an insurrection, rebellion, or riot;** (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a **felony or as a direct result of the Insured Person being engaged in an illegal occupation;** (f) an Insured Person being intoxicated, as defined by applicable state law in the state where the illness occurred or under the influence of narcotics unless administered or prescribed by Physician.
- Any **services provided by a local, state or federal government agency**, except when payment under this Policy is expressly required by federal or state law.
- **Any services required by state or federal law** to be supplied by a public school system or school district.

- Any **services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities, except for services rendered on an emergency basis where a legal liability exists for charges made to the Insured Person for such services.
- **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 an involuntary hold or prescribed by a Physician and listed as covered in this plan.
- **Professional services** performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.
- **Supplies received or purchased directly or on Your behalf** from any of the following:
  - Yourself, or a company under Your partial or complete ownership;
  - A person who is related to the Insured Person by blood, marriage or adoption.
- **Custodial Care.**
- **Private duty nursing** in the inpatient setting, except when provided as part of the Hospice Services benefit in this Policy.
- Inpatient room and board **charges in connection with a Hospital stay primarily for environmental change or physical therapy; Custodial Care or rest cures**; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
- Services received during **an inpatient stay when the stay is primarily related to** behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental health.
- **Complementary and alternative medicine services**, including but not limited to: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; meditation; visualization; acupuncture; acupressure; reflexology; rolfing; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnosis; energy-balancing; breathing exercises; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf; and any other alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. Services specifically listed as covered under "Rehabilitative Therapy" and "Habilitative Therapy" are not subject to this exclusion.
- Any services or supplies provided by or at a place for the aged, a nursing home, or any facility a significant portion of the activities of which include **rest, recreation, leisure**, or any other services that are not Covered Services.
- **Assistance in activities of daily living**, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or convalescent care.
- **Services performed by unlicensed practitioners** or services which do not require licensure to perform, for example mediation, breathing exercises, guided visualization.
- Inpatient room and board **charges in connection with a Hospital stay primarily for diagnostic tests** which could have been performed safely on an outpatient basis.
- **Services which are self-directed** to a free-standing or Hospital based diagnostic facility.
- Services ordered by a **Physician or other provider who is an employee or representative** of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

- Has not been actively involved in Your medical care prior to ordering the service, or
- Is not actively involved in Your medical care after the service is received.

This exclusion does not apply to mammography.

- **Dental services**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **Dental Implants**: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
- **Hearing aids** including but not limited to semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs), For the purposes of this exclusion, a hearing aid is any device that amplifies sound. Does not apply to cochlear implants.
- **Routine hearing tests** except as provided under Preventive Care.
- **Genetic screening** or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An **eye surgery solely for the purpose of correcting refractive defects** of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Outpatient **speech therapy**, expect as specifically stated in this Policy.
- **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self-esteem. This exclusion shall not include Reconstructive Surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and Reconstructive Surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
- **Aids or devices that assist with nonverbal communication**, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books except as specifically stated in this Policy.
- **Non-Medical counseling or ancillary services**, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities and developmental delays, except as otherwise stated in this Policy.
- **Services and procedures for** redundant skin surgery including abdominoplasty/panniculectomy, removal of skin tags, carinosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; rhinoplasty, and blepharoplasty **regardless of clinical indications**.
- Procedures, surgery or treatments **to change characteristics of the body to those of the opposite sex** including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery. This also includes any medical, surgical or psychiatric treatment or study related to sex change**.**
- Any treatment, prescription drug, service or supply to treat **sexual dysfunction**, enhance sexual performance or increase sexual desire.

- All services related to **the evaluation or treatment of fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including reversals of elective sterilization and 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. 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.
- Services primarily for **weight reduction or treatment of obesity including morbid obesity**, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Insured Person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
- **Routine physical exams or tests** that do not directly treat an actual Illness, Injury or condition, including those required by employment or government authority, physical exams required for or by an employer or for school, or sports physicals, except as otherwise specifically stated in this Plan.
- Therapy or treatment **intended primarily to improve or maintain general physical condition** or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected. This exclusion shall not include Habilitative services or therapies that are provided by a licensed therapist to keep, learn or improve skills needed for daily living.
- **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, etc. Except for wigs as specifically provided in the treatment of cancer).
- **Massage therapy**.
- **Educational services** except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.
- **Nutritional counseling** except when provided as part of home health care, treatment of an eating disorder, or treatment of diabetes, **or food supplements**, except as stated in this Policy.
- **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or

support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this Policy.

- **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and under 'Physical and/or Occupational Therapy/Medicine' in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- All **Foreign Country Provider charges** are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **Growth Hormone Treatment** except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition. Growth hormone treatment for idiopathic short stature or improved athletic performance is not covered under any circumstances.
- **Routine foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet, except for Insured Person's diagnosed with diabetes.
- **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 90 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the **services of a standby Physician**.
- Charges for **animal to human organ transplants**.
- **Claims received by Cigna after 15 months from the date service was rendered**, except in the event of a legal incapacity.

Prescription Drug Benefits

Pharmacy Payments

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

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

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

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

Your responsibility for covered Prescription Drugs and Related Supplies will always be the lowest of:
- the Copay or Coinsurance for the Prescription Drug, or
- Cigna's discounted rate for the Prescription drug; or
- the Pharmacy's Usual and Customary (U&C) charge for the Prescription Drug.

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

If You redeem a coupon or offer from a pharmaceutical manufacturer for a drug covered under this Policy, Cigna may not allow the dollar amount of the coupon or offer to reduce Your Annual Deductible, Copayment Percentage 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.

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 law restrict to sale by Prescription only, except for Insulin which does not require a prescription.
- Pharmaceuticals to aid smoking cessation.
- Insulin (no prescription required); syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary.
- 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 on a basis that is no less favorable than intravenously administered anti-cancer medications.
- All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.
- Contraceptive Drugs and devices approved by the FDA.
- Specialty Medications.

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.

Exclusions

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

- Drugs not approved by the Food and Drug Administration;
- Any drugs that are not on the Prescription Drug List and not otherwise approved as Medically Necessary.
- Drugs available over the counter that do not require a prescription by federal or state law except as otherwise stated in this Policy, or specifically required by 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 used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido/ and or sexual desire;
- Any drugs used for weight loss, weight management, metabolic syndrome, and antiobesity agents;
- Any drugs that are Experimental or Investigational as described under the Medical "Exclusions" section of the Policy; except as specifically stated in the sections of this Policy titled “Clinical Trials”, “Clinical Trial Costs” and “Off Label Drugs”;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals;
- Implantable contraceptive products inserted by the Physician are covered under the Plan’s medical benefits;
- Prescription and nonprescription supplies, devices, and appliances other than Related Supplies; except for those pertaining to Diabetic Supplies and Equipment;
- Prescription vitamins other than prenatal vitamins; dietary supplements, herbal supplements and fluoride other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA) ;
- Drugs used for cosmetic purposes that have no medically acceptable use, such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
- Injectable or Infused Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or Fractions are covered under the medical benefits of this Policy;
- Medications used for travel prophylaxis, except anti-malarial drugs;
- Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured 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.

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 Participating 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
- **Note:** Prescription Drugs approved by the Federal Drug Administration (FDA) for use in the treatment of cancer pain are covered, even if they exceed the recommended dosage or days' supply limits indicated above if the Prescription Drug is to treat an Insured Person who has intractable cancer pain.
- Tobacco cessation medications that are included on Cigna's Prescription Drug List are limited to two 90 day supplies per Year.
- Managed drug limits (MDL) may apply to dose and/or number of days' supply of certain drugs; managed drug limits are based on recommendations of the federal Food and Drug Administration (FDA) and the drug manufacturer.
- 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.

Prescription Drug List Exception and Prior Authorization Process

Prior Authorization or Step Therapy is required for certain Prescription Drugs and Related Supplies. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a Step Therapy determination. Step Therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If Your Physician believes Prescription Drugs or Related Supplies not on Cigna's Drug List are necessary, or wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call, or complete the appropriate Prior Authorization form and fax it to Cigna to request a Prescription Drug List exception or Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician can certify in writing that the Insured Person has previously used a Prescription Drug or Related Supply that is on Cigna's Prescription Drug List or in a Step Therapy Protocol, and the Prescription Drug or Related Supply has been detrimental to the Insured Person's health or has been ineffective in treating the condition and, in the opinion of the prescribing Physician, is likely to again be detrimental to the Insured Person's health or ineffective in treating the condition. The Prior Authorization or Prescription Drug List exception will be reviewed and completed by Cigna within 24 hours of receipt. The Physician should make this request before writing the prescription.

An expedited review may be requested by the prescribing Physician when an Insured Person is suffering from a health condition that may seriously jeopardize the Insured Person's life, health, or ability to regain maximum function or when an Insured Person is undergoing a current course of treatment using a drug not on Cigna's Prescription Drug List. The expedited review will be reviewed and completed by Cigna within 24 hours of receipt. The Physician should make this request before writing the prescription.

If the request is approved, Your Physician will receive confirmation. The Prior Authorization will be processed in Cigna's pharmacy claim system to allow You to have coverage for those Prescription Drugs or Related Supplies. The length of the Prior Authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When Your Physician advises You that coverage for the Prescription Drugs or Related Supplies has been approved, and writes the prescription, You should contact the Pharmacy to fill the prescription(s).

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

If You disagree with a coverage decision, You may appeal that decision in accordance with the provisions of this Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered. Please see the section of this Policy entitled "WHEN YOU HAVE A COMPLAINT OR AN APPEAL" which describes the process for the External Independent Review.

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

Reimbursement/Filing a Claim

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

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

Pediatric Vision Benefits for Care Performed by an Ophthalmologist or Optometrist

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

Definitions

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

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

Pediatric Vision Benefits

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

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

What Is Covered

In-Network Covered Benefits for Insured Persons through the end of the month in which the Insured Person reaches age 19 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 24 months for an Insured with partial sight, or whose sight is not fully correctable with surgery, pharmaceuticals, contact lenses or glasses. There are various low vision aids, such as the bioptic telescope, which can aid the Insured Person with their specific needs.

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

Exclusions

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

Limitations

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

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.

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.

Reimbursement/Filing a Claim

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

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

Cigna Vision
Claims Department
PO Box 385018
Birmingham, AL 35238-5018

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

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

General Provisions

Alternate Cost Containment Provision

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

Insurance with Other Companies

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

Medicare Eligibles

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

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

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

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him due to age.

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

When You Have a Complaint or an Appeal

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

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

Start with Member Services.

We are here to listen and help. If You have a concern regarding a person, a service, the quality of care, contractual benefits, an initial eligibility denial or a rescission of coverage, You can call Our toll-free number and explain Your concern to one of Our Customer Service representatives. Please call Us at

the Customer Service Toll-Free Number that appears on Your benefit identification card, explanation of benefits or claim form.

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

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

Appeals Procedure
To initiate an appeal, You must submit a request for an appeal in writing, within 180 days of receipt of a denial notice, to the following address:

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

You should state the reason why You feel Your appeal should be approved and include any information supporting Your appeal. If You are unable or choose not to write, You may ask to register Your appeal by telephone. Call Us at the toll-free number on Your benefit identification card, explanation of benefits or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a Physician or Dentist reviewer.

We will respond in writing or by electronic means to You or Your representative and the provider of record with a decision within 15 calendar days after We receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after We receive an appeal for a postservice coverage determination.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, We will provide this information to You as soon as possible and sufficiently in advance of the decision, so that You will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, We will provide the rationale to You as soon as possible and sufficiently in advance of the decision so that You will have an opportunity to respond.

Expedited Appeals
You may request that the appeal process be expedited if: (a) the time frames under this process would seriously jeopardize Your life, health or ability to regain maximum function or in the opinion of Your Physician would cause You severe pain which cannot be managed without the requested services; or (b) Your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If You request that Your appeal be expedited based on (a) above, You may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited Cigna appeal would be detrimental to Your medical condition.

Cigna's Physician reviewer, or Your treating Physician, will decide if the expedited appeal criteria apply. When an appeal is expedited, We will respond orally with a decision to You and Your representative or provider as soon as possible, not to exceed 72 hours, taking into account medical exigencies. We will respond orally to expedited appeals related to prescriptions for the alleviation of cancer pain within 24 hours of the receipt of all necessary information. We will follow up in writing within 24 hours of the oral response to an expedited appeal.

For any concurrent review of an urgent care request, coverage for the treatment shall be continued without additional liability to You until You are notified of the review decision.

Complaint/Appeals Assistance from the Commonwealth of Virginia

If You have any questions regarding an appeal concerning the health care services You have been provided, which have not been satisfactorily addressed, You may contact the Office of the Managed Care Ombudsman for assistance. The Virginia Bureau of Insurance (BOI), Office of the Managed Care Ombudsman may be contacted as follows:

Office of the Managed Care Ombudsman
Bureau of Insurance (BOI)
P.O. Box 1157
Richmond, VA 23218
Toll-Free: 1-877-310-6560
Richmond Metropolitan Area: 804-371-9032
E-mail:ombudsman@scc.virginia.gov
WebPage: Information regarding the Ombudsman
may be found by accessing State Corporation
Commission's Web Page at:
www.scc.virginia.gov

If You have quality of care or quality of service concerns, You may contact the Office of Licensure and Certification at any time, at the following:

Office of Licensure and Certification (OLC)
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond, VA 23233
Phone: 804-367-2104 – ask for MCHIP
Fax Line: 804-527-4503

No insured who exercises the right to file a complaint or an appeal shall be subject to disenrollment or otherwise penalized due to the filing of a complaint or appeal.

***External* Review**

If You are not fully satisfied with the decision of Cigna's appeal review regarding medical necessity, experimental/investigational, pre-existing condition, initial eligibility determination, rescission of health coverage, a determination of whether You are entitled to a reasonable alternative standard for a reward under a wellness program, or a determination of whether Your plan is complying with the non-quantitative treatment limitation provisions and parity in the application of medical management techniques consistent with the Mental Health Parity and Addiction Equity Act You or Your authorized representative, may request that Your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

You will be considered to have exhausted the internal appeal process if You have:

- completed Cigna's appeal process;
- filed an appeal requesting a review of an adverse determination, and, except to the extent that You agreed to a delay, have not received a written decision from Cigna within 15 days for pre-service claims and 30 days for post-service claims, following the date the appeal was filed with Cigna; or
- filed a request for an expedited internal appeal of an adverse determination with Cigna. You may file a request for an expedited external review of the adverse determination at the same time. Upon receipt of a request for an expedited external review of an adverse determination, the independent review organization (IRO) conducting the external review will determine whether You

are required to complete Cigna's expedited appeal process before it conducts the expedited external review. The IRO must promptly notify You of this determination, and either proceed with the expedited external review or wait until completion of the internal expedited appeal process.

- A request for an external review of an adverse determination may be made before You have exhausted Cigna's internal appeal process if Cigna agrees to waive the exhaustion requirement. If the exhaustion requirement is waived, You may file a request in writing for a standard external review.
- The request for an external review must be submitted within 120 days of Your receipt of a final adverse determination. Adverse determination in the context of external review means a determination has been made that an admission, availability of care, continued stay, or other health care service, based on the information provided, does not meet Cigna's requirements for Medical Necessity, appropriateness, level of care, health care setting, effectiveness, or is determined to be Experimental or Investigational.

Standard External Appeal
Within 45 days after the date it receives a request for a standard external review, the IRO will provide written notice of its decision to uphold or reverse the adverse determination.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, Cigna shall promptly approve coverage of the recommended or requested health care service or treatment.

Please note that review and response requirements imposed on the IRO may be different than those shown above if the adverse determination is related to Experimental or Investigational Treatment. Should You wish to request an External Appeal for an adverse determination based in Experimental or Investigational Treatment, please contact Customer Service at the number on the back of Your member ID card, or You can contact the Virginia Bureau of Insurance at the contact information shown above.

Expedited External Appeal
You may be entitled to make a request for an Expedited External Appeal if You receive:

- an adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an standard internal appeal involving an adverse determination would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function; or
- a final adverse determination if You have a medical condition where the time frame for completion of a standard external appeal would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, or if the final adverse determination concerns an admission, availability of care, continued stay or health care service for which You received Emergency Services but have not been discharged from a facility.

Retrospective adverse determinations are not eligible for an expedited review. If Your request is approved for an Expedited Appeal, the IRO assigned by the BOI will make a decision, as expeditiously as Your medical condition or circumstances requires, but in no event more than 72 hours after the date of receipt, to uphold or reverse the adverse determination. You, Cigna and the BOI will be provided written notice within 48 hours after the date of providing the initial determination.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, Cigna shall promptly approve coverage of the recommended or requested health care service or treatment.

Please note that review and response requirements imposed on the IRO may be different than those shown above if the adverse determination is related to Experimental or Investigational Treatment. Should You wish to request an External Appeal for an adverse determination based in Experimental or Investigational Treatment, please contact Customer Service at the number on the back of Your member ID card, or You can contact the Virginia Bureau of Insurance at the contact information shown above.

Notice of Benefit Determination on Appeal
Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: (1) the professional qualifications and licensure of the person or persons reviewing the appeal; (2) a statement of the reviewers' understanding of the reason for Your appeal; (3) (1) information sufficient to identify the claim; (2) the specific reason or reasons for the denial decision, including the reviewers' decision in clear terms and the medical rationale in sufficient detail for You to respond further to Cigna's position; (3) reference to the specific Policy provisions on which the decision is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding Your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and (6) information about, and contact information for, the Managed Care Patient Assistance Program. A final notice of adverse determination will include a discussion of the decision.

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

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 during the benefit year. Coverage will continue during the 90 day grace period and if You are receiving advanced premium tax credits claims for services rendered after the first 30 days of the grace period will be pended. However, if We do not receive Your premium, due in full before the end of the grace period, Your coverage will be terminated on the last day 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 on the last date of the Grace Period. Please see "General Provisions," for further information regarding cancellation and reinstatement.

Cost-Share Reduction Contingency: If You purchased Your Policy through a federally-facilitated or state-based marketplace and You satisfy certain income thresholds, You may have been eligible for, and Your Policy may include, cost-sharing reductions under federal law. In that case, Your cost-sharing obligation (e.g., copayments, coinsurance or deductible, as applicable) are less than the cost-sharing obligation that would otherwise apply under this Policy.

Any such cost-share reduction is predicated upon payment by the federal government to Cigna of amounts that are intended to reimburse Cigna for the difference between Your cost-sharing obligation and the cost-sharing obligation that would otherwise apply under this Policy. In the event that the federal government fails to make such payments or such payments are otherwise determined to be impermissible or unavailable, Your reduced cost-sharing obligation (e.g., copayments, coinsurance or deductible, as applicable) may, upon 30 days' prior written notice, be increased to the amount that would otherwise apply under this Policy. In such a case, Your cost-sharing obligations will continue to be administered in accordance with applicable federal and state laws and regulations.

In the event that Cigna is prohibited, for any reason, from increasing Your cost sharing obligation in accordance with this section, Your premium may be increased upon 75 days prior written notice to reflect the loss of reimbursement to Cigna.

Cancellation by Cigna: 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 a Marketplace or the 90 day grace period for plans purchased from a Marketplace.
2. When You become ineligible for this coverage.
3. If You have committed, any act or practice that constitutes fraud, or made an intentional misrepresentation of material fact in connection with this Policy or coverage.
4. When We cease to offer policies of this type to all individuals in Your class. In this event, Virginia 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.
5. When We cease offering any plans in the individual market in Virginia, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
6. When the Insured no longer resides, lives, or works in the Coverage Area.
7. When Cigna determines that any premium payment for this Policy is being paid directly or indirectly from any source other than You, Your Family Members or an Acceptable Third Party Payor; however, if You, Your Family Members or an Acceptable Third Party Payor make all premium payments for this Policy that are due after the date of Cigna's determination, the Policy shall remain in effect, subject to all other terms and conditions contained herein.

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

Cancellation by You: You may cancel this Policy:

You may cancel Your Policy at any time by written notice delivered or mailed to Cigna. It will be effective upon receipt of notice or on such later date as You may specify in the notice. In the event of cancellation, Cigna will return promptly the unearned portion of any premium paid. The earned premium will be computed pro rata. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

Modification of Coverage: We reserve the right to modify this policy, including Policy provisions, benefits and coverages, so long as such modification is consistent with state or federal law and effective on a uniform basis among all individuals with coverage under this same Policy form. We will only modify this Policy for all Insured Persons in the same class and covered under the same Policy form, and not just on an individual basis. We will send written notice of intent to increase the annual premium or any deductible 75 days prior to the renewal of coverage. This Individual Plan renews on January 1 of each Year.

Reinstatement: If this Policy cancels because You did not pay Your premium within the time granted You for payment, and if We, or an agent We have authorized to accept premium, then accepts a late premium payment from You without asking for an application for reinstatement, We will reinstate this Policy. However, if We require an application for reinstatement and give You a conditional receipt for Your late premium payment, We will only reinstate this Policy if either We approve Your reinstatement application, or lacking such approval, upon the forty-fifth day following the date on Our conditional receipt if We have not by that date notified You in writing of Our disapproval of Your application. If an application is required and approved, the Policy will be reinstated as of the approval date.

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

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

Renewal: This Policy renews on a Calendar Year basis.

Fraud: If the Insured Person has committed, any act or practice that constitutes fraud, or made an intentional misrepresentation of material fact in connection with this Policy or coverage, then any and all coverage under this Policy shall be void and of no legal force or effect.

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

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

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

- The Insured Person(s) are the only persons entitled to receive benefits under this Policy. ANY ACT, PRACTICE, OR OMISSION THAT CONSTITUTES 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, Florida 33630-3365
1-877-484-5967

- 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 the termination, breach of, or inability to perform under any provider contract of any Insured Person's Primary Care Provider who was furnishing health care services to the Insured Person; or of any other Participating Provider's termination or breach of, or inability to perform under, any provider contract.
- Continuation of Care after Termination of a Provider whose participation has terminated:

Cigna will provide benefits to You or Your Insured Family Member(s) 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.
- Except where the Provider has been terminated for cause, ongoing treatment of an Insured Person who at the time of termination has been diagnosed with a terminal illness, provided that such treatment is directly related to the terminal illness. Treatment will, at the Insured Person's option, continue for the remainder of the Insured Person's life.
- 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.
- Failure by Cigna to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.
- If Insured Person(s) were covered by a prior Individual Cigna Policy that is replaced by this Policy with no lapse of coverage:
  - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer

Insurance effective at any one time on the Insured Person under a like Cigna Policy or Policies is limited to the one such Policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and Cigna will return all premiums paid for all other such Policies.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physicians:

This medical Policy does require that the Insured Person selects a Primary Care Physician and obtain a referral from a Primary Care Physician in order to receive all benefits available under this medical Policy. A Primary Care Physician may serve an important role in meeting health care needs by providing or arranging for medical care for each Insured Person. We provide the opportunity to select a Primary Care Physician from a list provided by Cigna for each Insured Person. If the Insured person chooses to select a Primary Care Physician, the Primary Care Physician You select for Yourself may be different from the Primary Care Physician You select for each of Your Family Member(s).

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 Your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

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

How to File a Claim for Benefits

Notice of Claim: Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Cigna at P.O. Box 188061 Chattanooga, TN 37422. Notice should include the name of the Insured Person, and Claimant if other than the Insured Person, and the Member ID Number.

Unpaid Premiums: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

Claim Forms: When Cigna receives 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 Cigna a written statement of the nature and extent of the loss within the time limit stated in the Proofs 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: If the Policy provides for periodic payment for a continuing loss, written proof of loss must be given to Cigna within 90 days after the end of each period for which Cigna is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, Cigna shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

Assignment of Claim Payments:

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

We will recognize and consider any assignment made under the Policy, only if:

1. It is duly executed on a form acceptable to Us; and
2. a copy is on file with Us; and
3. it is made by a provider licensed and practicing within the United States.

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

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

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid to the Insured Person. Loss of life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the Insured Person's estate. Any other benefits unpaid at death may be paid, at Cigna's option, either to the Insured Person's beneficiary or the Insured Person's estate. If benefits are payable to the Insured Person's estate or a beneficiary who cannot execute a valid release, Cigna can pay benefits up to $2000, to someone related to the Insured Person or beneficiary by blood or by marriage whom Cigna considers to be entitled to the benefits. Cigna will be discharged to the extent of any payment made in good faith. Cigna may pay all or a portion of any indemnities provided for health care services to the health care services provider, unless the Insured Person directs otherwise in writing by the time proofs of loss are filed. Cigna cannot require that the services be rendered by a particular health care services provider.

Claim Determination 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 2 business days after receiving the request if no additional information is required. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify the Insured Person or their representative within two business days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date the Insured Person or their representative responds to the notice.

If the determination periods above would (a) seriously jeopardize the Insured Person's life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Insured Person's health condition, cause them severe pain which cannot be managed without the requested services, Cigna will make the 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 one calendar day, 24 hours after receiving the request. Determinations related to cancer pain prescriptions will be determined within 24 hours. However, if necessary information is missing from the expedited request, Cigna will notify the Insured Person or their representative within one calendar day 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. Determinations may be provided orally, followed within 3 calendar days by written or electronic notification.

If 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 two business 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 two business days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

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

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

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

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

Premiums

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

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

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 during the benefit year. Coverage will continue during the 90 day grace period and if You are receiving advanced premium tax credits claims for services rendered after the first 30 days of the grace period will be pended. However, if We do not receive Your premium, due in full before the end of the grace period, Your coverage will be terminated on the last day 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 on the last date 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

c. A change in residence

These changes will be effective on the first of the month following the change, unless as otherwise stated on Your premium notice.

Cigna also reserves the right to change the premium with written notice to You 75 days prior to the proposed date of renewal. 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.