Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 days' written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")

Cigna Connect 50-4 Plan

If You Wish To Cancel Or If You Have Questions

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

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

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

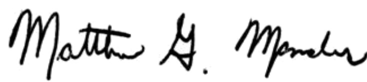
THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Policy was issued to You by Cigna Health and Life Insurance Company (referred to herein as Cigna) based on the information You provided in Your application. If You know of any misstatement in Your application, You should advise the Company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

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

Guaranteed Renewable

Medical coverage under this Policy continues on a monthly basis, subject to payment of premiums by the Insured Person. Cigna will renew this Policy except for the specific events stated in the "Who Is Eligible For Coverage?" section of this Policy. Coverage under this Policy is effective at 12:01 a.m. **Eastern time** on the Effective Date shown on the Policy's specification page.

Signed for Cigna by:



Matthew G. Manders, President

Anna Krishtul, Corporate Secretary

IMPORTANT NOTICES

Direct Access to Obstetricians and Gynecologists

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

Selection of a Primary Care Provider

This plan allows for 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact Customer Service at the phone number listed on the back of your ID card.

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

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Introduction

About This Policy

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

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

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

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

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

IF, WITHIN 2 YEARS AFTER THE EFFECTIVE DATE OF YOUR PARTICIPATION IN THE POLICY, WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED OR THAT ANY PERSON APPLYING FOR COVERAGE KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND THIS COVERAGE AS OF THE ORIGINAL EFFECTIVE DATE. 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 A NETWORK-ONLY PLAN

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

- Services for Stabilization and initial treatment of a Medical Emergency, or
- Two sessions per Year for the purpose of diagnosis or assessment of mental health, or
- Medically Necessary services that are not available through an In-Network (Participating) Provider.

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

Choosing a Primary Care Physician (PCP)

A Primary Care Physician may serve an important role in meeting health care needs by providing or arranging for medical care for each Insured Person. For this reason, when You enroll as an Insured Person, You will be asked to select a Primary Care Physician (PCP). Your PCP will provide Your regular medical care and assist in coordinating Your care. You are encouraged to choose a PCP for Yourself and each covered Family Member from the network of Participating Providers. You may select Your PCP by calling the customer service phone number on Your ID card or by visiting Our website at www.mycigna.com. 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). You have the right to designate any Primary Care Physician who participates in Our network and is available to accept You or Your Family Members. If You do not select a PCP during enrollment or within 31 days of being notified that Your PCP is no longer Participating with the Plan, We will select a PCP for You. You may change Your PCP up to once a month by visiting Our website at www.mycigna.com or by contacting Us at the customer service phone number on Your ID card. Any change in PCP will become effective on the first day of the month following Your request.

If You Need a Specialist

Your PCP is important to the coordination of Your care. While this Plan does not require referrals to visit specialists, it is very important that You work with Your PCP to help manage Your care and keep Your PCP apprised of all Your health care needs. Please be aware that obtaining a referral is not itself a guarantee of payment for services.

Changing Primary Care Physicians

You may request a transfer from one Primary Care Physician to another by contacting Us at the Customer Service number on ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, We will notify You 30 days in advance, for the purpose of selecting a new Primary Care Physician, if they choose.

If Your PCP Leaves the Network

If Your PCP or In-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 In-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.

Network Exception

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

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

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

Continuity of Care

If Your PCP ceases to be a Participating Physician, We will notify You. Under certain medical circumstances, We may continue to reimburse Covered Expenses from Your PCP or a specialist You've been seeing at the Participating Provider benefit level even though he or she is no longer affiliated with Cigna's network. If you are undergoing an active course of treatment for an acute or chronic condition and continued treatment is Medically Necessary, You may be eligible to receive continuing care from the Non-Participating Provider for a specified time, subject to the treating Provider's agreement. You may also be eligible to receive continuing care if You are in your second or third trimester of pregnancy. In this case, continued care may be extended through Your delivery and include a period of postpartum care.

Such continuity of care must be approved in advance by Cigna, and Your doctor must agree to accept our reimbursement rate and to abide by Cigna's policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider who ceases to be a Participating Provider will not be available, such as when the provider loses his/her license to practice or retires.

You may request continuity of care from Cigna after your Participating Provider's termination from Cigna's network; start by calling the toll-free number on your ID card. Continuity of care must be Medically Necessary and approved in advance by Us. Continuity of care will cease upon the earlier of:

- Successfully transition of Your care to a Participating Provider, or
- Completion of Your treatment; or
- The next open enrollment period; or
- The length of time approved for continuity of care ends.

Note Regarding Health Savings Accounts (HSAs)

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

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

Important Information Regarding Benefits

Prior Authorization Program

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

PRIOR AUTHORIZATION FOR INPATIENT SERVICES

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

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

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

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

Please note that emergency admissions will be reviewed post admission.

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

PRIOR AUTHORIZATION FOR OUTPATIENT SERVICES

Prior Authorization is also required for certain outpatient procedures and services in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO CERTAIN ELECTIVE OUTPATIENT PROCEDURES AND SERVICES MAY RESULT IN A PENALTY.

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

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

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

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

Retrospective Review

If Prior Authorization was not performed Cigna will use retrospective review to determine if a scheduled or Emergency admission was Medically Necessary. In the event the services are determined to be Medically Necessary, benefits will be provided as described in this Policy. If it is determined that a service was not Medically Necessary, the Insured Person is responsible for payment of the charges for those services. For retrospective review determinations, Cigna shall make the determination within thirty working days of receiving all necessary information. Cigna shall provide notice in writing of Cigna's determination to a covered person within ten working days of making the determination.

Prior Authorization for Prescription Drugs

Prior Authorization is required for certain Prescription Drugs and Related Supplies. **For complete, detailed information about Prescription Drug authorization procedures, exceptions and Step Therapy, please refer to the section of this Policy titled "Prescription Drug Benefits"**.

To verify Prior Authorization requirements for Prescription Drugs and Supplies, including which Prescription Drugs and Supplies require Authorization, You can:

- call Cigna at the number on the back of your ID card, or
- log on to http://www.cigna.com/ifp-drug-list.

Missouri Utilization Review Decisions and Procedures

For initial determinations, Cigna shall make the determination within thirty-six hours, which shall include one working day, of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

- In the case of a determination to certify an admission, procedure or service, Cigna shall notify the provider rendering the service by telephone or electronically within 24 hours of making the initial certification, and provide written or electronic confirmation of a telephone or electronic notification to the covered person and the provider within two working days of making the initial certification;

- In the case of an adverse determination, Cigna shall notify the provider rendering the service by telephone or electronically within 24 hours of making the adverse determination; and shall provide written or electronic confirmation of a telephone or electronic notification to the covered person and the provider within one working day of making the adverse determination.

For concurrent review determinations, Cigna shall make the determination within one working day of obtaining all necessary information:

- In the case of a determination to certify an extended stay or additional services, Cigna shall notify by telephone or electronically the provider rendering the service within one working day of making the certification, and provide written or electronic confirmation to the covered person and the provider within one working day after telephone or electronic notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;

- In the case of an adverse determination, Cigna shall notify by telephone or electronically the provider rendering the service within twenty-four hours of making the adverse determination, and provide written or electronic notification to the covered person and the provider within one working day of a telephone or electronic notification. The service shall be continued without liability to the covered person until the covered person has been notified of the determination.

For retrospective review determinations, Cigna shall make the determination within thirty working days of receiving all necessary information. Cigna shall provide notice in writing of Cigna's determination to a covered person within ten working days of making the determination.

When conducting utilization review or making a benefit determination for emergency services, Cigna shall cover emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services. When a covered person receives an emergency service that requires immediate post evaluation or post stabilization services, Cigna shall provide an authorization decision within 60 minutes of receiving a request; if the authorization decision is not made within 30 minutes, such services shall be deemed approved.

A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. Cigna shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who requests such information.

Cigna shall have written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. In cases where the provider or a covered person will not release necessary information, Cigna may deny certification of an admission, procedure or service.

If an authorized representative of Cigna authorizes the provision of health care services, Cigna shall not subsequently retract its authorization after the health care services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition, the health benefit plan terminates before the health care services are provided or the covered person's coverage under the health benefit plan terminates before the health care services are provided.

In a case involving an initial determination or a concurrent review determination, a health carrier shall give the provider rendering the service an opportunity to request on behalf of the enrollee a reconsideration of an adverse determination by the reviewer making the adverse determination.

The reconsideration shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination is not available within one working day.

If the reconsideration process does not resolve the difference of opinion, the adverse determination may be appealed by the enrollee or the provider on behalf of the enrollee. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an adverse determination.

BENEFIT SCHEDULE

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

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

Remember, services from Non-Participating/Out-of-Network Providers are not covered except for initial care to treat and Stabilize an Emergency Medical Condition and two sessions per Year for the purpose of diagnosis or assessment of mental health. For additional details see the "How The Plan Works" section of Your Policy.

BENEFIT INFORMATION **Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.**	**PARTICIPATING PROVIDER – YOU PAY (Based on the Negotiated Rate)** **AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY** **YOU PAY:**
Medical Benefits	
Annual Plan Deductible	
Individual	$50
Family	$100
Out-of-Pocket Maximum	
Individual	$1,500
Family	$3,000 The following do not accumulate to the Out-of-Pocket Maximum: Penalties and Policy Maximums
Co-insurance	You and Your Family Members pay 10% of Charges after the Annual Plan Deductible

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

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.	PARTICIPATING PROVIDER – YOU PAY (Based on the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY YOU PAY:
Physician Services	
Office Visit / Home Visit	
Primary Care Physician (PCP)	$8 Copayment per office visit, Deductible waived
Specialist, (including consultant, referral and second opinion services) (PCP Referral and/or Plan Authorization is NOT required) **Note**: if a Copayment applies for OB/GYN visits: If Your doctor is listed as a PCP in the provider directory, You or Your Family Member will pay a PCP Copayment. If Your doctor is listed as a specialist, You or Your Family Member will pay the specialist Copayment.	10%
Surgery in Physician's office	10%
Outpatient Professional Fees for Surgery (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy)	10%
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	10%
In-hospital visits	10%
Allergy testing and treatment/injections	10%
Cigna Telehealth Connection Services	
▪ Virtual visit with a **Cigna Connection Physician** Limited to minor acute medical conditions Note: if a Cigna Telehealth Connection Physician issues a Prescription, that Prescription is subject to all Plan Prescription Drug benefits, limitations and exclusions.	$8 Copayment per office visit, Deductible waived
▪ **Covered Services from any other Participating Physician delivered by Virtual means** Not limited to minor acute medical conditions	Same benefit as when service provided in person

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

BENEFIT INFORMATION **Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.**	**PARTICIPATING PROVIDER – YOU PAY (Based on the Negotiated Rate)** **AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY** **YOU PAY:**
Rehabilitative Services Maximum does not apply to services for treatment of Autism Spectrum Disorders. **Physical/Manipulation (excluding Chiropractic) Therapy** Maximum of 20 visits per Insured Person, per calendar year **Occupational Therapy** Maximum of 20 visits per Insured Person, per calendar year. **Speech Therapy** Unlimited visits per Insured Person, per calendar year.	 $8 Copayment per office visit, Deductible waived $8 Copayment per office visit, Deductible waived 10%
Chiropractic Services Maximum of 26 visits per Insured Person, per calendar year. **Note**: Additional visits may be authorized based on Medical Necessity.	10%
Cardiac Rehabilitation Maximum of 36 visits per Insured Person, per calendar year. Limits based on Medical Necessity guidelines.	10%
Pulmonary Rehabilitation Maximum of 20 visits per Insured Person, per calendar year. Limits based on Medical Necessity guidelines.	10%

BENEFIT INFORMATION **Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.**	**PARTICIPATING PROVIDER – YOU PAY (Based on the Negotiated Rate)** **AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY** **YOU PAY:**
Habilitative Services Maximums for Habilitative Services do not apply to services for the treatment of Autism Spectrum Disorders.	
Physical/Manipulation (excluding Chiropractic) Therapy Maximum of 20 visits per Insured Person, per calendar year for all therapies.	$8 Copayment per office visit, Deductible waived
Occupational Therapy Maximum of 20 visits per Insured Person, per calendar year.	$8 Copayment per office visit, Deductible waived
Speech Therapy Unlimited visits per Insured Person, per calendar year.	10%
Note: Maximums for Rehabilitative services do not apply to Habilitative services.	
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	Copay or Coinsurance applies for specific benefit provided
Women's Contraceptive Services, Family Planning and Sterilization	0%, Deductible waived
Male Sterilization	Copay or Coinsurance applies for specific benefit provided

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.	PARTICIPATING PROVIDER – YOU PAY (Based on the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY 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	PCP or Specialist Office Visit benefit applies
Prenatal services, Postnatal and Delivery (billed as "global" fee)	10%
Hospital Delivery charges	10%
Prenatal testing or treatment billed separately from "global" fee	10%
Postnatal visit or treatment billed separately from "global" fee	PCP or Specialist Office Visit benefit applies
Autism Spectrum Disorders	
Diagnosis of Autism Spectrum Disorder	
Office Visit	PCP or Specialist Office Visit benefit applies
Diagnostic testing	10%
Treatment of Autism Spectrum Disorder (see "Comprehensive Benefits: What the Policy Pays For" section for specific information about what services are covered)	Copay or Coinsurance applies for specific benefit provided
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 150 days per Insured Person per calendar year	10%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.	PARTICIPATING PROVIDER – YOU PAY (Based on the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY YOU PAY:
Home Health Services Maximum of 100 visits per Insured Person, per calendar year.	10%
Private Duty Nursing Maximum of 82 visits per Insured Person per calendar year	10%
Durable Medical Equipment	10%
Prosthetics	10%
Hospice	
Inpatient	Inpatient Hospital Services benefit applies
Outpatient	10%
Dialysis	
Inpatient	Inpatient Hospital Services benefit applies
Outpatient	10%
Mental, Emotional or Functional Nervous Disorders	
Inpatient (includes Acute and Residential Treatment)	Inpatient Hospital Services benefit applies
Outpatient (Includes individual, group, intensive outpatient and partial hospitalization and two Non-Participating Provider office visits.)	
Office Visit	10%
All other Outpatient services	10%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Plan Deductible unless specifically waived.	PARTICIPATING PROVIDER – YOU PAY (Based on the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY YOU PAY:
Substance Use Disorder Inpatient Rehabilitation (Includes Acute and Residential Treatment) Outpatient (Includes individual, group, intensive outpatient and partial hospitalization) Office Visit All other Outpatient services	Inpatient Hospital Services benefit applies 10% 10%
Organ and Tissue Transplants (see benefit detail in "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.) **Cigna LIFESOURCE Transplant Network® Facility** **Travel Benefit,** (Only available through Cigna Lifesource Transplant Network ® Facility) Travel benefit maximum payment of $8,000 per transplant **Non-Lifesource Participating Facility specifically contracted to perform Transplant Services** **Participating Facility NOT specifically contracted to perform Transplant Services**	 0% 10% Not Covered
Infusion and Injectable Specialty Prescription Medications and related services or supplies administered by a medical professional in an office or outpatient facility	10%
Dental Care (other than Pediatric) Limited to treatment for accidental injury to natural teeth within six months of the accidental injury	10%

BENEFIT INFORMATION	PARTICIPATING PROVIDERS (Based on the Negotiated Rate) YOU PAY:	NON-PARTICIPATING PROVIDERS (Based on Maximum Reimbursable Charge) YOU PAY:
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Emergency Services		
NOTE: This Plan covers Emergency Services from Participating and Non-Participating Providers as shown:		
Emergency Services		
Hospital Emergency Room		
Emergency Medical Condition	10%	10%
Non-Emergency Medical Condition	10%	Not Covered
Urgent Care Center Facility		
Emergency Medical Condition	$25 Copayment per visit, Deductible waived	$25 Copayment per visit, Deductible waived
Non-Emergency Medical Condition	$25 Copayment per visit, Deductible waived	Not Covered
Ambulance Services		
Note: coverage for Medically Necessary transport to the nearest facility capable of handling an Emergency Medical Condition.		
Emergency Transport	10% for Ground, Air or Water transport	10% for Ground, Air or Water transport
Non-Emergency Transport	Not Covered	Not Covered

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

BENEFIT INFORMATION	RETAIL PHARMACY	CIGNA HOME DELIVERY PHARMACY
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
Note: **You can obtain a 30 day supply of any Prescription Drug or refill at any Participating Retail Pharmacy.** **You can obtain up to a 90 day supply of Your Prescription Drug or refill at either a 90 Day Retail Pharmacy or through the Cigna Home Delivery Pharmacy.** 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 Copayment or Coinsurance shown in this Benefit Schedule.		
Prescription Drug Deductible	**Annual Plan Deductible applies to Prescription Drugs**	
	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	$4 Copayment, Deductible waived per prescription or refill 30 day supply – at any Participating Pharmacy or Up to a 90 day supply – at a 90 Day Retail Pharmacy. You pay a Copayment for each 30 day supply.	$12 Copayment, Deductible waived per Prescription or refill 90 day maximum supply.
Tier 2: Non-Preferred Generic	$10 Copayment, Deductible waived per prescription or refill 30 day supply – at any Participating Pharmacy or Up to a 90 day supply – at a 90 Day Retail Pharmacy. You pay a Copayment for each 30 day supply.	$30 Copayment, Deductible waived per Prescription or refill 90 day maximum supply.

BENEFIT INFORMATION	RETAIL PHARMACY	CIGNA HOME DELIVERY PHARMACY
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Tier 3: Preferred Brand	$25 Copayment, Deductible waived per prescription or refill 30 day supply – at any Participating Pharmacy or Up to a 90 day supply – at a 90 Day Retail Pharmacy. You pay a Copayment for each 30 day supply.	$75 Copayment, Deductible waived per Prescription or refill 90 day maximum supply.
Tier 4: Retail Non-Preferred Brand	50% per prescription or refill 30 day supply – at any Participating Pharmacy or Up to a 90 day supply – at a 90 Day Retail Pharmacy.	50% per Prescription or refill 90 day maximum supply.
Tier 5: Retail Specialty	30% per prescription or refill, Deductible waived 30 day supply – at any Participating Pharmacy or Up to a 30 day supply – at a 90 Day Retail Pharmacy.	20% per Prescription or refill, Deductible waived 30 day maximum supply.
Preventive Drugs regardless of Tier Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive including: • women's contraceptives that are Prescribed by a Physician and are Generic or Brand Name with no Generic alternative • smoking cessation products, limited to a maximum of 2 90 day regimens	0%, Deductible waived per prescription or refill 30 day supply at any Participating Pharmacy or Up to a 90 day supply – at a 90 Day Retail Pharmacy.	0%, Deductible waived per Prescription or refill 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.

90-day Retail Pharmacy means a Participating retail Pharmacy that has an agreement with Cigna, or with an organization contracting on Cigna's behalf, to provide specific Prescription Drug products or supplies, including, but not limited to: extended days' supply, Specialty Medications and customer support services. Please note: not every Participating Pharmacy is a 90-Day Retail Pharmacy, however every Participating Pharmacy can provide a 30-day supply of Prescription Drug products or supplies.

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 local, State or Federal government program, including a grantee directed by a government program to make payments on its behalf; 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 publically available criteria and does not in any way consider the health status of any Insured Person in determining whether to make such payments on Your behalf.

Alcoholism Treatment Facility is a residential or nonresidential facility certified by the Department of Mental Health for treatment of alcoholism.

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

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

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

Autism Spectrum Disorders means a neurological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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.

Chemical Dependency means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

Cigna LifeSOURCE Transplant Facility is a facility with a transplant program that is included in the Cigna LifeSOURCE Transplant Network®.

Cigna Telehealth Connection refers to a Covered Service delivered through Virtual means.

Cigna Telehealth Connection Physician refers to a Physician who is part of a designated network from one or more organizations contracted with Cigna to provide Virtual treatment for minor acute medical conditions.

Cigna Telehealth Connection Physician Service means a telehealth visit, initiated by the Insured Person and provided by a Cigna Telehealth Connection Physician, providing Virtual treatment for minor acute medical conditions such as a cold, flu, sore throat, rash or headache.

Note: the network that provides Cigna Telehealth Connection Physicians is separate from the Plan network, and is only available for services detailed under "Cigna Telehealth Connection" in the "Covered Services and Benefits" section of this Plan.

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** means 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.**

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) if a Hospital, accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another appropriately licensed organization, and
    (iii) acting within the scope of the Provider's license and (if applicable) accreditation.

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

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

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services 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; and 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 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.

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.

Durable Medical Equipment is defined as items which:

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

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

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

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

1) placing the health of the individual in serious jeopardy;
2) serious impairment to bodily functions;
3) serious dysfunction of any bodily organ or part;
4) inadequately controlled pain; or
5) with respect to a pregnant woman who is having contractions:

    a) that there is inadequate time to effect a safe transfer to another hospital before delivery; or
    b) that the transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Services means a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider.

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

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.

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. It is an accumulation of the Individual Deductible paid by each Family Member for Covered Expenses for medical Covered Services during a Year. 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 in a Year, any 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 Member means Your spouse, children or other persons enrolled for coverage under this Policy. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?".

Family Out-of-Pocket Maximum applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. It is an accumulation of the Deductible, Coinsurance and Copayments each Family Member has accrued during a Year. Each Insured Person can contribute up to his or her Individual Out-of-Pocket amount toward the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum has been met in a Year, You and Your Family Member(s) will no longer be responsible to pay Coinsurance or Copayments 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.

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.

Grievance means a written complaint submitted by or on behalf of an enrollee regarding the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; claims payment, handling or reimbursement for health care services; or matters pertaining to the contractual relationship between an enrollee and a health carrier.

Habilitative Services are those services that are:

(i) designed to assist a child to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame,

(ii) are expected to result in significant and measurable therapeutic or developmental improvement over a clearly defined period of time, and

(iii) are individualized and there is documentation outlining quantifiable, measurable and attainable treatment goals.

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.

Home Visit means medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.

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 a legally constituted institution (or an institution which operates pursuant to law) having organized facilities for the care are treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under the supervision of a staff of one or more licensed physicians and which provides 24-hour nursing service by registered nurses on duty or call.

The term Hospital does not mean convalescent nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addict or alcoholic, even though the facilities are operated as a separate institution by a hospital.

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

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 is an accumulation of Covered Expenses. It includes Deductibles, Copayments and Coinsurance for Covered medical and pharmacy Services. 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 or Copayment for medical or pharmacy 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 amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

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

Injury means an accidental bodily injury.

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

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

Intensive Care Unit means the part of a hospital service specifically designed as an intensive care unit permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other hospital rooms or wards, the care to include close observation by trained and qualified personnel whose duties are primarily confined to the part of the hospital for which an additional charge is made.

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

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

- A percentile and 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 Participating/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 and 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 Participating/In-Network Cigna Providers for the same services; or
- A percentage of a fee schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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

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

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

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

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

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

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 Pharmacy/Out-of-Network Pharmacy is a retail Pharmacy with which Cigna has NOT contracted to provide prescription services to Insured Persons; or a mail-order Pharmacy with which Cigna has NOT contracted to provide mail-order prescription services to Insured Persons.

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; or
- Medical Decision Making (the Physician's diagnosis and plan of treatment).

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

Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing facilities, rehabilitation Hospitals and 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/In-Network 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/In-Network Provider is a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services with regard to a particular Policy under which an Insured Person is covered. A Participating Provider may also be referred to in this Policy by type of Provider—for example, a Participating Hospital or Participating Physician.

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

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

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

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

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

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

Policy is the set of benefits, conditions, exclusions, limitations, and premiums described in this document, including the Policy specification page, the completed and accepted application for coverage, 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 on 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. This formulary listing is available upon request. You can view the drug list at www.mycigna.com.

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

Primary Care Physician is a Physician:

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

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.

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

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

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

Reconstructive Surgery is surgery to correct the appearance of abnormal looking features or characteristics of the body caused by birth defects, Injury, 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.

Related Supplies are diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for self-injectables, 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.

Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

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

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

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

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

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

Smoking Cessation Attempt means 4 tobacco cessation counseling sessions per attempt of at least 10 minutes each (including telephone counseling, group counseling and individual counseling); and one 90-day regimen per attempt of certain Food and Drug Administration (FDA)-approved tobacco cessation medications (including prescription medications and over-the-counter medications with a Physician's prescription; please see the No Cost Preventive Care Drug List on mycigna.com for details).

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

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

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

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

- Targets the underlying disease pathology;
- Modifies disease sequel;
- Targets conditions that are rare, chronic, and costly;
- Requires close supervision and monitoring of therapy for safety and effectiveness;
- 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, that no material deterioration of the condition is likely to occur before an individual may be transferred or result from or occur during the transfer of the individual from a facility.

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

Telehealth/Telemedicine Medical Service is a health care service initiated or provided by a Physician for purposes of patient assessment, diagnosis, consultation, treatment or the transfer of medical data that requires the use of advanced telecommunications technology other than by telephone or fax unless otherwise stated in this Policy.

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

Utilization Review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage.

Virtual, with respect to Cigna Telehealth Connection, means Covered Services that are delivered via secure telecommunications technologies, including telephones and internet.

We/Us/Our is Cigna Health and Life Insurance Company, Inc. (Cigna).

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 Missouri. 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 Missouri; and
- You live in the Enrollment Area in which You are applying, and intend to continue living there for the entire period for which enrollment is sought; 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):

- Your lawful spouse.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, or Your spouse's unmarried children, 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 may require 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 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 60 days of the date of birth, and pay any additional premium. Cigna will allow you an additional 10 days from the date the forms and instructions are provided in which to enroll the newly born child. Coverage for a newborn dependent child enrolled within 60 days of birth will be retroactive to the date of the child's birth.
- An adopted child, including a child who is placed with You for adoption, is automatically covered for 31 days from the date of 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 60 days of the date of adoption, and pay any additional premium. Cigna will allow you an additional 10 days from the date the forms and instructions are provided in which to enroll the newly born child. Coverage for an adopted dependent child enrolled within 60 days of adoption will be retroactive to the date of the child's placement for adoption or initiation of a suit of adoption.
- If a court has ordered an Insured to provide coverage for an eligible child (as defined above) coverage will be automatic for the first 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 60 days of the court order date, and pay any additional premium. Court-ordered coverage for a dependent child enrolled within 60 days of the court order will be retroactive to the date of the court order.

When Can I Apply?

Application to Enroll or Change Coverage

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

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

Annual Open Enrollment Period

The Annual Open Enrollment Period is a specified period of time 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 OFF Marketplace 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 voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gaining or becoming a dependent through marriage, birth, adoption or placement for adoption, or through a child support order or other court order; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An 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 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).

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; or
- 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.

Triggering events for a special enrollment period ON Marketplace are:

- An eligible individual, and any dependent(s), loses his or her minimum essential coverage pregnancy-related Medicare/Medicaid coverage, or medically needy coverage (only once per calendar year), or the qualified individual or dependent is enrolled in any non-calendar year group or individual health insurance coverage (even if they have the option to renew such coverage). The date of the loss of minimum essential coverage, pregnancy-related coverage, or medically needy coverage is the last day the individual would have coverage under the plan. The date of loss of non-calendar year insurance is the last day of the plan or policy year; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gaining or becoming a dependent through marriage, birth adoption or placement for adoption, or through a child support order or other court order; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee; or
- At the option of the Marketplace, the enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation, or if the enrollee or his or her dependent dies;
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- A qualified individual or dependent becomes newly eligible for enrollment in a QHP when they satisfy the Marketplace's citizenship requirement or are released from incarceration;
- 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 enrollee or dependent is determined newly eligible or ineligible for APTC or has a change in eligibility for cost-sharing reductions;
    - A qualified individual or his or her dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan, including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage;
    - A qualified individual who was previously ineligible for APTC because of a household income below 100% FPL and who was also ineligible for Medicaid because he or she was living in a non-Medicaid expansion state, either experiences a change in income or moves to a different state, making them newly eligible for APTC.

  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) and either (1) had minimum essential coverage for one or more days during the 60 days preceding the date of the move, or (2) was living outside of the United States; or

- The qualified individual who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act (or their dependent), 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; or A qualified individual (or their dependent) who is enrolled in minimum essential coverage and is a victim of domestic abuse or spousal abandonment seeks to enroll in coverage separate from the perpetrator;
- A qualified individual or dependent applies for Marketplace or Medicaid or CHIP coverage during open enrollment or due to a qualifying life event, but is determined ineligible for Medicaid or CHIP after the Exchange open enrollment period has ended or more than 60 days after a qualifying life event;
- The qualified individual or enrollee (or their dependent) adequately demonstrates to the Marketplace that a material error related to plan benefits, service area or premium influenced their decision to purchase a QHP; or
- At the option of the Marketplace, the qualified individual provides satisfactory evidence to verify eligibility for an insurance affordability program or enrollment in a QHP following termination of Exchange enrollment due to a failure to verify such status within established time periods, or is under 100% of the federal poverty level and did not enroll in coverage while waiting for HHS to verify citizenship, status as a national or lawful presence.

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

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

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

For all other triggering events the effective dates are:

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

Specific Causes for Ineligibility

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

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

Active Duty Military Service

Conditions occurring while an Insured Person is participating in the military service of are not covered by this Plan. If an Insured Person's becomes an active duty member of any branch of military service, he or she must notify Us. We will, following receipt of such notification, issue a pro-rata refund of unearned premium.

Continuation

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

How The Policy Works

Services performed by a Non-Participating (Out-of-Network) Provider are not covered under this Plan except for Emergency Services and two sessions per year for the purpose of diagnosis or assessment of mental health.

Benefit Schedule

The Benefit Schedule shows the Individual and Family Deductible and Out-of-Pocket Maximums, and 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 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 Expenses will be paid at the Participating Provider benefit schedule for the initial care of an Emergency Medical Condition.

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

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before benefits are available. Deductibles apply to all Covered Expenses as described in the Definitions section of 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. There are two ways an Insured Person can meet his or her Deductible:

- When an Insured Person meets his or her Individual Deductible, that Insured Person's benefits will be paid accordingly, whether any applicable Family Deductible is satisfied or not.
- If one or more Family Members are covered under this Policy, 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 Individual or Family Deductible is required for the remainder of that Year.

Out-of-Pocket Maximum

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

The Individual Out-of-Pocket Maximum is an accumulation of Covered Expenses. It includes Deductibles, Copayments and Coinsurance for Covered medical and pharmacy Services. Once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Expenses, You will no longer have to pay any Coinsurance or Copayment for medical or pharmacy 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 amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.The Family Out-of-Pocket Maximum applies if You have a family plan, and one or more of your Family Member(s) are Insured under this Policy. It is an accumulation of the Individual Covered Expenses, including Deductibles, Copayments and Coinsurance for Covered medical and pharmacy Services, paid by each Family Member for Covered Expenses for medical Covered Services during a Year. Each Insured Person can contribute up to the Individual Out-of-Pocket Maximum toward the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum is satisfied in a Year, any remaining Individual Deductibles will be waived for the remainder of the Year. The amounts of the Individual and the Family Out-of-Pocket Maximum are described in the Schedule of Benefits section of this Policy.

Penalties

A Penalty is an amount of Covered Expenses that is:

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

Penalties will apply under the following circumstances:

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

Penalties are applied before any benefits are available.

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

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

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 and two sessions per year for the purpose of diagnosis or assessment of mental health.

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, Intensive Care Unit 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.)

For any eligible condition that is authorized by Cigna, this Policy provides indicated benefits for Covered Expenses for Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility. Payment of benefits for Skilled Nursing Facility services is subject to all of the following conditions:

- You and Your Family Members must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing Facility.
- The services must be consistent with the Illness, Injury, degree of disability and medical needs. Benefits are provided only for the number of days required to treat the Illness or Injury.
- You and Your Family Members must remain under the active medical supervision of a Physician treating the Illness or Injury for which You and Your Family Members are confined in the Skilled Nursing Facility.

Note: No benefits will be provided for:

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

Hospice Care Program

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

This Policy provides benefits for Covered Expenses for Hospice Care including palliative and supportive medical, nursing and other health services through home or inpatient care Insured Persons who have a Terminal Illness and for the families of those persons, including bereavement counseling for the families for up to 12 months following the death of the terminally ill Insured Person.

To be eligible for this benefit, the Hospice Services 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.

In order to be eligible for benefits for a Hospice Care Program, the Insured Person must be suffering from a Terminal Illness, as certified by his or her Physician, notice of which is submitted to Us in writing.

The Physician must consent to the Hospice Care Program, and must be consulted in the development of the treatment plan. The Hospice Services Provider must submit a written treatment plan to Us every 30 days.

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;
- A second opinion rendered by a specialist in that specific cancer diagnosis area when an insured person with a newly diagnosed cancer is referred to such specialist by his or her attending 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;
- Wigs (initial wig following cancer treatment, not to exceed one per Benefit Period);
- Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered;
- The first pair of contact lenses or the first pair of eyeglasses when required as a result of eye surgery;
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products;
- Infusion and Injectable Specialty Prescription Medications may require Prior Authorization or precertification and will only be covered when provided by an approved Participating Provider specifically designated to supply that specialty prescription medication.

Durable Medical Equipment

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

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

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

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

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

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

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.

Services for Rehabilitative Therapy (Physical/Manipulation Therapy, Occupational Therapy and Speech Therapy)

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

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

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

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

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

Maximums for Short-term Rehabilitative Services shown in the Benefit Schedule do not apply to services for treatment of Autism Spectrum Disorders.

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

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

Services for Pulmonary and Cardiac Rehabilitation

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

This Policy provides benefits for Covered Expenses incurred for pulmonary rehabilitation and 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.

Habilitative Services

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

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

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

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

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

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

Maximums for Habilitative Services shown in the Benefit Schedule do not apply to services for treatment of Autism Spectrum Disorders.

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

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

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

In order to qualify for benefits, services for Mental, Emotional or Functional Nervous Disorders, substance use disorder or Chemical Dependency must meet the following conditions:

- Services must be for the treatment of a Mental, Emotional or Functional Nervous Disorder, substance use disorder or Chemical Dependency that can be improved by standard medical practice.
- The Insured Person must be under the direct care and treatment of a Physician for the condition being treated.
- Services must be those which are regularly provided and billed by a Hospital or a Physician.
- Services are covered only for the number of days or visits which are Medically Necessary to treat the Insured's condition.
- Inpatient services must be received in a Hospital.

Mental, Emotional or Functional Nervous Disorder coverage will include at least two sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor, licensed clinical social worker, or, subject to contractual provisions, a licensed marital and family therapist, acting within the scope of such license. This Policy provides benefits for Covered Expenses that meet all of the following requirements:

(1) Charges are for the purpose of diagnosis or assessment, but not dependent upon findings; and

(2) Services are not subject to any conditions of preapproval, and are reimbursable as long as the provisions stated are satisfied; and

(3) Services will be subject to the same coinsurance, co-payment and deductible that apply to regular office visits for any other illness.

Dental Care

This Policy provides benefits for dental care for an accidental Injury to natural teeth, subject to the following:

- services must be received during the 6 months following the date of Injury;
- no benefits are available to replace or repair existing dental prostheses even if damaged in an eligible accidental Injury; and
- damage to natural teeth due to chewing or biting is not considered an accidental Injury under this Policy.

Anesthesia for Dental Procedures

Benefits are payable for general anesthesia/radiation therapy and associated facility charges for dental procedures rendered in a Hospital, Ambulatory Surgical Center, or office for an Insured Person but only when such services are Medically Necessary. General anesthesia/radiation therapy and associated facility charges for such procedures are Medically Necessary and, thus, payable for (a) children, (b) the severely disabled and (c) Insured Persons who have medical or behavioral conditions which require hospitalization or general anesthesia when dental care is provided.

Pregnancy and Maternity Care

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

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

All comprehensive benefits described in this Plan are available for maternity services. Services include testing for pregnant women for lead poisoning. 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?".

Post-discharge care shall consist of a minimum of two visits in the home performed no later than 48 hours following the mother and newborn child's discharge from the Hospital, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. Services provided by the registered professional nurse or Physician shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality, in the condition of the mother or the child, observed by the nurse shall be reported to the attending physician as medically appropriate.

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

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

Preventive Care Services

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

The Plan provides benefits for routine preventive care services. Payment will be provided for Covered Expenses for preventive care services including the following:

- Routine physical exams, including
- guidance and counseling regarding substance use disorder, alcohol misuse, tobacco use, obesity, exercise and healthy diet/nutritional counseling.
- Two Smoking Cessation Attempts (maximum of 4 counseling sessions per attempt); Prescription Drugs for smoking cessation treatment are covered under the Prescription Drug benefit.
- Annual mammogram, Pap test, PSA, and colorectal cancer screening.
- Charges for or in connection with the diagnosis, treatment and appropriate management of osteoporosis for persons with a condition or medical history for which bone mass measurement is medically necessary, provided such services are received by a Physician licensed to practice medicine and surgery in Missouri.
- Evidence-based items or services that have an A or B rating in current recommendations of the U. S. Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- Benefits include initial hearing aids provided to a newborn for initial amplification following a newborn hearing screening (including any necessary rescreening, audiological assessment and follow-up; see "Preventive care"). A hearing aid is an electronic device worn or implanted for the purpose of amplifying sound and assisting in the physiological process of hearing;
- With respect to women, preventive care and screenings, provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration (HRSA), including (but not limited to) all Food and Drug Administration (FDA) approved contraceptive methods for women, sterilization procedures, and patient education and counseling for all women (and dependent daughters) with reproductive capacity, and Medically Necessary BRCA genetic testing for women who have any symptoms or any significant, proven risk factors of developing breast cancer.

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 vaccinations), employment, school or sports.

Missouri First Steps Program

Cigna participates in Missouri's Part C Early Intervention System, "First Steps." "First Steps" provides coverage for early intervention services described in this section that are delivered by early intervention specialists who are health care professionals licensed by the state of Missouri and acting within the scope of their professions for children from birth to age three identified by the Part C early intervention system as eligible services for persons under Part C of the Individuals with Disabilities Education Act.

Early Intervention Services means medically necessary speech and language therapy**,** occupational therapy, physical therapy, and assistive technology devices for children from birth to age three who are identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act and shall include services under an active individualized family service plan that enhances functional ability without effecting a cure. An individualized family service plan is a written plan for providing early intervention services to an eligible child and the child's family that is adopted in accordance with 20 U.S.C. Section 1436.

Clinical Trials

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

Clinical Trials means charges made for routine patient services incurred as the result of the phase II, III, or IV of a clinical trial that is associated with the prevention, early detection, or treatment of cancer, approved by one of the following agencies:

- The National Institutes of Health.
- The Centers for Disease Control and Prevention.
- The Agency for Health Care Research and Quality.
- The Centers for Medicare & Medicaid Services.
- 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.
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- The Department of Veterans Affairs.
- The Department of Defense.
- The Department of Energy.

Phase III and IV of a clinical trial must be approved or funded by one of the following entities:

- one of the National Institutes of Health (NIH);
- an NIH Cooperative Group or Center;
- the FDA in the form of an investigational new drug application;
- the federal Departments of Veteran's Affairs or Defense;
- an institutional review board in the State of Missouri that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CRF 46); or
- a qualified research entity that meets the criteria for NIH Center support grant eligibility.

Phase II of a clinical trial must be:

- approved by the National Institute of Health (NIH); or
- approved by the National Cancer Institute Center, and be conducted at an academic or National Cancer Institute Center.

Additionally, the person must be actually enrolled in the clinical trial and not just applying the clinical trial protocol for phase II.

Covered Expenses include drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

In the case of treatment under a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, noninvestigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the noninvestigational alternatives.

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed herein as Exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Orally Administered Anticancer Medications

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.

Autism Spectrum Disorders and Applied Behavior Analysis

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

Coverage is provided for the diagnosis and treatment of autism spectrum disorders, and care prescribed or ordered for an Insured Person diagnosed with an autism spectrum disorder by a licensed Physician or licensed psychologist, including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician's or licensed psychologist's license, including but not limited to: psychiatric care; psychological care; habilitative or rehabilitative care, including behavior analysis therapy; therapeutic care; and pharmacy care. Coverage cannot be denied on the basis that it is educational or habilitative in nature

The terms used above are defined as follows:

- Autism spectrum disorders means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- Diagnosis of autism spectrum disorders means Medically Necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder.
- Treatment for autism spectrum disorders means care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed Physician or licensed psychologist, including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician's or licensed psychologist's license, including, but not limited to: psychiatric care; psychological care; habilitative or rehabilitative care, including applied behavior analysis therapy; therapeutic care; and pharmacy care.
- Autism service provider means any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst.
- Applied behavior analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.
- Habilitative or rehabilitative care is professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual.
- Line therapist means an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.
- Pharmacy care means medications used to address symptoms of an autism spectrum disorder prescribed by a licensed Physician, and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications, only to the extent that such medications are included in the insured's health benefit plan.
- Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- Psychological care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
- Therapeutic care means services provided by licensed speech therapists, occupational therapists, or physical therapists.

Organ and Tissue Transplants

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

To be eligible for benefits, organ and tissue transplants must be Prior Authorized by Cigna before services are rendered (see the "Prior Authorization Program").

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

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

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

Coverage will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant surgery. Transplant services include medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, kidney/liver, liver, lung, pancreas or intestinal, including small bowel, small bowel/liver or multivisceral.
- The evaluation, preparation and delivery of the donor organ.
- The removal of the organ from the donor. Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.
- The transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada. Benefits will only be provided at a designated Cigna LIFESOURCE Transplant Network® facility.

Reimbursement may not be denied for an otherwise Covered Expense incurred for any organ transplant procedure solely on the basis that such procedure is deemed Experimental or Investigational unless supported by the determination of the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services that such procedure is either Experimental or Investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable.

Transplant services received at Participating (In-Network) Provider facilities specifically contracted with Cigna for those Transplant services are payable at the In-Network level.

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

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

Transplant Travel Services

Coverage is provided for transportation and lodging expenses incurred by You in connection with a pre-approved organ/tissue transplant that if reimbursed by Cigna would be characterized by the Internal Revenue Service as non-taxable income pursuant to Publication 502, and subject to the following conditions and limitations. Benefits for transportation and lodging are available to You only if You are the recipient of a pre-approved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term "recipient" includes an Insured Person receiving authorized transplant-related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the Member receiving the transplant will include Charges for:

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

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

The following are specifically excluded travel expenses:

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

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

Travel expenses for organ and tissue transplants are limited to any maximum shown in the Schedule of Benefits.

Antigen Testing

This policy provides benefits for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation when performed in a facility accredited by the American Association of Blood Banks or its successors, the College of American Pathologists, the American Society for Histocompatibility and Immunogenetics (ASHI) or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is licensed under the Clinical Laboratory Improvement Act.

Treatment of Diabetes

Medical services for Diabetes are covered on the same basis as any other medical condition. This Policy provides benefits for Covered Expenses including outpatient Diabetes Self-Management Training and education, Physician prescribed medically appropriate 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:

test strips for blood glucose monitors; visual reading and urine test strips; tablets which test for glucose, blood glucose monitors on Cigna's Prescription Drug List, ketones and protein; lancets and lancet devices; 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 and alcohol swabs.

Treatment Received from Foreign Country Providers

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

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

Cigna Telehealth Connection

Cigna Telehealth Connection refers to a Covered Service delivered through Virtual means. There are two components to Cigna Telehealth Connection:

- **Cigna Telehealth Connection Program:** services for the treatment of minor acute medical conditions such as colds, flu, ear aches, are available from a specific set of Providers known as Cigna Telehealth Connection Physicians. You can find on www.mycigna.com; You may access Cigna Connection Telehealth Physicians by going to www.mycigna.com and click on Find a Doctor, Dentist or Facility; type "Telehealth/Telemedicine/eVisit under 'search criteria'.

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

  If the Cigna Telehealth Connection 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, as appropriate.
  - Providing discharge instructions through email.

  You have the option to have records from each Cigna Telehealth Connection Physician visit for a minor acute medical condition sent to Your regular Physician.

- **Cigna Telehealth Connection other services**, the second component of this benefit, are also available from any Physician who is willing and qualified to deliver appropriate Covered Services through Virtual means. Note: this benefit does not include Cigna Telehealth Connection Physician Service described above.

  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.

Treatment for Temporomandibular Joint Dysfunction (TMJ)

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

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 services 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 prescribed by a Physician in lieu of hospitalization.

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

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

Mastectomy and Related Procedures

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 also include treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in providing these services. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer.

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

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

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

Enteral Nutrition

This Policy provides coverage medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes formulas and low protein modified food products prescribed by a Physician for a child until 6 years of age with phenylketonuria (PKU) or any other inherited disease of amino and organic acids. Low protein modified food products are foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the discretion of a Physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

For other diagnosis not specified above, coverage for enteral nutrition and supplies required for enteral feedings is provided when all of the following conditions are met:

- It is necessary to sustain life or health.
- It is used in the treatment of, or in association with, a demonstrable disease, condition or disorder.
- It requires ongoing evaluation and management by a Physician.
- It is the sole source of nutrition or a significant percentage of daily caloric intake.

Coverage for enteral nutrition does not include:

Regular grocery products that meet the nutritional needs of the patient (e.g. over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or

Medical food products that:

- are prescribed without a diagnosis requiring such foods;
- are used for convenience purposes;
- have no proven therapeutic benefit without an underlying disease, condition or disorder;
- are used as a substitute for acceptable standard dietary intervention; or
- are used exclusively for nutritional supplementation.

External Prosthetic Appliances and Devices

This Policy provides benefits for Covered Expenses made or ordered by a Physician for: the initial purchase, fitting, and replacement of external prosthetic appliances and devices available only by prescriptions which are Medically Necessary for the alleviation or correction of Injury, Illness or congenital defect.

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

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

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

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

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

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 those provided by an Urgent Care facility) and two sessions per year for the purpose of diagnosis or assessment of mental health.
- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed as Covered Services** in this Policy.
- Services for **treatment of complications of non-covered procedures** or services; except for services for Emergency Medical Conditions or services resulting from complications related to an approved Clinical Trial.
- Services or supplies that are **not Medically Necessary**.
- Services or supplies that are considered to be for **Experimental Procedures or Investigative Procedures**.
- Services **received before the Effective Date of coverage**.
- Services **received after coverage under this Policy ends**.
- Services **for which You have no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, **under any workers' compensation, employer's liability law or occupational disease law**, even if the Insured Person does not claim those benefits.
- Conditions caused by: (a) an **act of war (declared or undeclared)**; (b) the **inadvertent release of nuclear energy** when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person **participating in the military service of any country**; (d) an Insured Person **participating in an insurrection, rebellion, or riot;** (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a **felony** (whether or not charged) **or as a direct result of the Insured Person being engaged in an illegal occupation;** (f) an Insured Person being intoxicated, as defined by applicable state law in the state where the illness occurred or under the influence of illegal narcotics or non-prescribed controlled substances unless administered or prescribed by Physician.
- Any **services provided by a local, state or federal government agency**, except when payment under this Policy is expressly required by federal or state law.
- Any **services required by state or federal law** to be supplied by a public school system or school district.
- Any **services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- **If the Insured Person is eligible for Medicare** Part A, B or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
- **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this plan.

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

  This exclusion does not apply to mammography.
- **Dental services**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **Dental Implants**: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.

- **Hearing aids** including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as provided under Preventive Care for hearing aids for initial amplification necessary to assist in the development of cognitive, language, and communicative skills, limited to the least expensive professionally adequate device. For the purposes of this exclusion, a hearing aid is any device that amplifies sound. This Exclusion does not apply to cochlear implants.
- **Routine hearing tests** except as provided under Preventive Care which include necessary rescreening, audiological assessment and follow-up, and initial amplification. The screening will include the use of at least one of the following physiological technologies: automated or diagnostic brainstem response (ABR); otacoustic emissions (OAE); or other technologies approved by the Missouri Department of Health.
- **Genetic screening** or pre-implantations genetic screening: general population-based genetic screening performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An **eye surgery solely for the purpose of correcting refractive defects** of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self-esteem or to treat psychological or psychosocial complaints regarding one's appearance. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
- **Aids or devices that assist with nonverbal communication**, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- **Non-Medical counseling or ancillary services**, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, employment counseling, back school, return to work services, work hardening programs and driving safety, , except as otherwise stated in this Policy.
- **Services and procedures for** redundant skin surgery, including abdominoplasty/panniculectomy, removal of skin tags, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; varicose veins; rhinoplasty, blepharoplasty, and orthognathic surgeries **regardless of clinical indications**.
- Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex unless such services are deemed medically necessary or otherwise meet applicable coverage requirements.
- Any treatment, prescription drug, service or supply to treat **sexual dysfunction**, enhance sexual performance or increase sexual desire.
- All services related to **the evaluation or treatment of fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including elective sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT).
- **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- All **non-prescription Drugs**, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription, except for Insulin**; All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision** and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, and **Self-administered Injectable Drugs**, except as 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 or as required by law for diabetic patients), shoe inserts, foot orthotic devices.
- Services primarily for **weight reduction or treatment of obesity including morbid obesity**, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Insured Person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
- **Routine physical exams or tests** that do not directly treat an actual Illness, Injury or condition, including those required by employment or government authority, physical exams required for or by an employer or for school, or sports physicals, except as otherwise specifically stated in this Plan.
- Therapy or treatment **intended primarily to improve or maintain general physical condition** or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- **Items which are furnished primarily for personal comfort or convenience** (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs (except as specifically provided in the treatment of cancer), etc.).
- **Massage therapy**.
- **Educational services** except for Diabetes Self-Management Training Program, treatment for Autism, or as specifically provided or arranged by Cigna.
- **Nutritional counseling or food supplements**, except as stated in this Policy.
- **Exercise equipment, comfort items and other medical supplies and equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded 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 'Services for Rehabilitative Therapy (Physical/Manipulation Therapy, Occupational Therapy and Speech Therapy' in the section of this Policy titled "Comprehensive Benefits: What the Policy Pays For".
- All **Foreign Country Provider charges** are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits: What the Policy Pays For".

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

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 Copayments 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 at www.cigna.com/ifp-drug-list.

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 Copayment 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 will not allow the dollar amount of the coupon, or offer to reduce Your annual Deductible, Copayment and/or Coinsurance. Cigna has the right to determine the amount and duration of any reduction, coupon or financial incentive available for any specific drug covered under this Policy.

Prescription Drugs and Specialty Medication Covered as Medical

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

Covered Expenses

If an Insured Person, 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. Coverage also includes charges for the refilling of an eye drop prescription prior to the last day of the prescribed dosage period without regard to a coverage restriction for early refill of prescription renewals provided the prescribing Physician authorizes such early refill.

What Is Covered

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

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 a mail order pharmacy program.
- The drug or medicine must not be used while the Insured Person is 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 pre-certification.

Exclusions

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

- Drugs not approved by the Food and Drug Administration;
- Any drugs that are not on the Prescription Drug List and not otherwise approved as Medically Necessary;
- Drugs available over the counter that do not require a prescription by federal or state law except as otherwise stated in this Policy, or specifically required under the Patient Protection and Affordable Care Act (PPACA);
- Drugs that do not require a Federal legend (a Federal designation for drugs requiring supervision of a Physician), other than insulin;
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- Injectable 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” and any benefit language concerning “Off Label Drugs”;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals;
- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies; except for those pertaining to Diabetic Supplies and Equipment;
- Implantable contraceptive products inserted by the Physician are covered under the Plan’s medical benefits;
- Prescription vitamins (other than prenatal vitamins), herbal supplements and dietary supplements, and fluoride other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);
- Drugs used for cosmetic purposes that have no medically acceptable use: such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
- Injectable or infused immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions are covered under the medical benefits of the Plan;
- Medications used for travel prophylaxis, except anti-malarial drugs;
- Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured’s condition. Growth hormone therapy for idiopathic short stature, or improved athletic performance is not covered under any circumstances;

- Drugs obtained outside the United States;
- Any fill or refill of Prescription Drugs and Related Supplies to replace those lost, stolen, spilled, spoiled or damaged before the next refill date;
- Replacement of Prescription Drugs and Related Supplies due to loss or theft;
- Drugs used to enhance athletic performance;
- Drugs which are to be taken by or administered to the Insured Person while a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- Any drugs, medications, or other substances dispensed or administered in any outpatient setting. This includes, but is not limited to, items dispensed by a Physician.
- 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 and Non-Preferred Brand and up to a 30-day supply of Specialty Medications, unless limited by the drug manufacturer's packaging: or
- Up to a 90 day supply, at a Participating 90 Day 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. To locate a Participating 90 Day Retail Pharmacy you can call the Customer Service number on Your ID card or go to www.cigna.com/ifp-providers.
- Up to a 90-day supply at a mail-order Pharmacy for Preferred Generic, Non-Preferred Generic, Preferred Brand and Non-Preferred Brand and up to a 30-day supply of Specialty Medications, unless limited by the drug manufacturer's packaging; or
- Tobacco cessation medications that are included on Cigna's Prescription Drug List are limited to two 90-day supplies per Year.
- Managed drug limits (MDL) may apply to dose and/or number of days’ supply of certain drugs; managed drug limits are based on recommendations of the federal Food and Drug Administration (FDA) and the drug manufacturer.
- To a dosage and/or dispensing limit as determined by the P&T Committee.
- Infusion and Injectable Specialty Prescription Medications may require Prior Authorization.
- If a prescription drug covered by the Plan is prescribed in a single dosage amount for which the particular prescription drug is not manufactured in such single dosage amount and requires dispensing the particular prescription drug in a combination of different manufactured dosage amounts, Cigna will only impose one Copayment for the dispensing of the combination of manufactured dosages that equal the prescribed dosage for the prescription drug. The Copayment requirement will not apply to prescriptions in excess of a 30-day supply. Cigna provides reimbursement forms for the additional Copayment if the override is not in place prior to filling the prescription.

Drug claim forms for are available upon written request to:

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

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

Prescription Drug Formulary Updates

The Prescription Drug List is reviewed four times a year, and updated as follows:

- changes in coverage such as adding new Drugs to the Prescription Drug List and moving Drugs to lower-cost tiers, are made on an ongoing basis.
- changes such as removing Drugs from the Prescription Drug List, or determining Drugs require Step Therapy are made once each Year on the Policy Year date.
- You or Your Family Member(s) who are using a drug that is removed from the Prescription Drug List will be notified in writing 90 days prior to the drugs removal from the Prescription Drug List.

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

You can also view the Prescription Drug List at www.cigna.com/ifp-drug-list.

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

Authorization, Exception and Appeal Process for Prescription Drugs and Related Supplies

Authorization from Cigna is required for certain Prescription Drugs and Related Supplies, meaning that Your Physician must obtain authorization from Cigna before the Prescription Drug or Related Supply will be covered.

Prior Authorization

When Your Physician prescribes certain Prescription Drugs or Related Supplies, including high cost and Specialty Medications, Cigna requires Your Physician to obtain authorization before the prescription or supply can be filled. Your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

Step Therapy

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 some higher-cost and Specialty Medications for treatment of conditions including allergies, asthma, diabetes, high cholesterol, mental health and stomach acid reflux. We may require You 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. The Prescription Drugs and Related Supplies that require Step Therapy can be identified on the Prescription Drug List at www.mycigna.com. If Your Physician prescribes a drug for You that is on the Step Therapy list, after You initially fill the Prescription You and Your Physician will receive a letter from Cigna informing You of the Step Therapy Drug You will be required to use when You refill the Prescription. To obtain Step Therapy Authorization, Your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

Exceptions for Prescription Drugs and Related Supplies not on the Prescription Drug List

If Your Physician prescribes a Prescription Drug or Related Supply not on Cigna's Prescription Drug List, he or she can request that Cigna make an exception and agree to cover that drug or supply for Your condition. To obtain an exception for a Prescription Drug or Related Supply Your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

Prescription Drug and Related Supply Authorization and Exception Request Process

To obtain an exception, Physician may call Cigna, or complete the appropriate form and fax it to Cigna to request an exception. Your Physician can certify in writing that You have 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 Your health or has been ineffective in treating Your condition and, in the opinion of Your Physician, is likely to again be detrimental to Your health or ineffective in treating the condition. The exception request will be reviewed and completed by Cigna within 72 hours of receipt.

Expedited Review of a Prior Authorization, Step Therapy or Prescription Drug Exception Request

An expedited review may be requested by Your Physician when You are suffering from a health condition that may seriously jeopardize the Your life, health, or ability to regain maximum function or when You are 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.

If the request is approved, Your Physician will receive confirmation. The Authorization/Exception 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 Authorization will be granted until You no longer use the Prescription Drug or Related Supply for which the Authorization or Exception was approved. When Your Physician advises You that coverage for the Prescription Drugs or Related Supplies has been approved, You should contact the Pharmacy to fill the prescription(s).

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

Appeal of a Prior Authorization, Step Therapy or Prescription Drug Exception Denial

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

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

Coverage of New Drugs

All new Food and Drug Administration (FDA)-approved drug products (or new FDA-approved indications) are designated as Non-Prescription Drug List drugs until the Cigna business decision team makes a placement decision on the new drug (or new indication), which decision shall be based in part on the P & T Committee's clinical review of the drug. The P&T Committee makes a reasonable effort to review all new FDA approved drug products (or new FDA approved indications) within 90 days of its release to the market. The business decision team must make a reasonable effort to review a new FDA-approved drug product (or new indications) within 90 days, and make a decision on each new FDA approved drug product (or new FDA approved indication) within 180 days of the its release onto the market, or a clinical justification must be documented if this timeframe is not met..

Reimbursement/Filing a Claim

When You purchase Prescription Drugs or Related Supplies through a retail Participating Pharmacy You will pay any applicable Copay, Coinsurance or Deductible shown in the Schedule at the time of purchase. You do not need to file a claim form.

If You purchase the Prescription Drug or Related Supplies through a non-Participating Pharmacy, You will pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

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

Claims and Customer Service

Drug claim forms for are available upon written request to:

For Retail Pharmacy claims:

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

For Mail-order Pharmacy claims:

Cigna Home Delivery Pharmacy
P.O. Box 1019
Horsham PA 19044-1019

1-800-835-3784

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

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

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.

Covered Benefits

In-Network Covered Benefits for Insured Persons, through the end of the month in which the Insured Person turns 19 years of age, include:

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

    *Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.
- Frames – One frame for prescription lenses from Pediatric Frame Collection. Only frames in the Pediatric Frame Collection are covered at 100%. Non-collection Frames: Member cost share up to 75% of retail.
- Elective Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year), including the professional services.
- Therapeutic Contact Lenses are covered for a one year supply, regardless of the contact lens type, including professional services, in lieu of lenses and frame benefit. Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction are not covered.
- Low Vision Coverage: Supplemental professional low vision services and aids are covered in full once every 24months for an Insured with partial sight, or whose sight is not fully correctable with surgery, pharmaceuticals, contact lenses or glasses. There are various low vision aids, such as the bioptic telescope, which can aid the Insured Person with their specific needs.

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

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.
- For or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
- Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.
- Services provided Out-of-network without Cigna's prior approval are not covered.

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 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

Insurance with Other Insurers

If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined. Note: The coverage under this plan is secondary to any automobile no-fault or similar coverage.

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.

Coordination of Benefits

This section describes what this Plan will pay for Covered Expenses that are also covered under one or more other Plans. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits in the form of payment or services for:

- An insurance Plan issued to an individual/nongroup or a group; or a self-insured group health plan providing benefits in the form of reimbursement or services for medical care or treatment/items.
- Governmental benefits as permitted by law, except for Medicaid, Medicare and Medicare supplement policies.
- Medical benefits coverage under any form of group or individual automobile insurance.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Primary Plan

The Plan that pays first as determined by the Order of Benefit Determination Rules below.

Secondary Plan

The Plan that pays after the Primary Plan as determined by the Order of Benefit Determination Rules below. The benefits under the Secondary Plan are reduced based on the benefits under the Primary Plan.

Allowable Expense

The portion of a Covered Expense used in determining the benefits this Plan pays when it is the Secondary Plan. The Allowable Expense is the lesser of:

- the charge used by the Primary Plan in determining the benefits it pays;
- the charge that would be used by this Plan in determining the benefits it would pay if it were the Primary Plan, and
- the amount of the Covered Expense.

If the benefits for a Covered Expense under your Primary Plan are reduced because you did not comply with the Primary Plan's requirements (for example, getting pre-certification of hospital admission or a second surgical opinion), the amount of the Allowable Expense is reduced by the amount of the reduction.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this Plan or any date before this section or any similar provision takes effect.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one that applies:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
    - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
    - then, the Plan of the parent with custody of the child;
    - then, the Plan of the spouse of the parent with custody of the child;
    - then, the Plan of the parent not having custody of the child, and
    - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Plan, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits Payable

If this Plan is the Primary Plan, the amount this Plan pays for a Covered Expense will be determined without regard for the benefits payable under any other Plan.

If this Plan is the Secondary Plan, the amount this Plan pays for a Covered Expense is the Allowable Expense less the amount paid by the Primary plan during a Claim Determination Period.

The difference between the amount that this Plan pays when it is the Secondary Plan and what it would have paid as the Primary Plan will be recorded as a benefit reserve for you. This benefit reserve will be used to pay any Covered Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide benefits under this Plan;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Covered Expenses during the Claim Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Covered Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

If while covered under this Plan, you are also covered by another Cigna individual or group Plan, you will be entitled to the benefits of only one Plan. You may choose this Plan or the Plan under which you will be covered. Cigna will then refund any premium received under the other Plan covering the time period both policies were in effect. However, any claim payments made by Cigna under the Plan you elected to cancel will be deducted from any such refund of premium.

Recovery of Excess Benefits

If this Plan is the Secondary Plan and Cigna pays for Covered Expenses that should have been paid by the Primary Plan, or if Cigna pays any amount in excess of what it is obligated to pay, Cigna will have the right to recover the actual overpayment made.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. No such request will be made more than 12 months after date of the actual overpayment except in cases of fraud or misrepresentation by the health care provider. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

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.

Cigna will estimate the amount Medicare would have paid, and pay as secondary to that estimated amount if an Insured Person is eligible to enroll for Part B of Medicare but is not enrolled.

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

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

NOTICE OF GRIEVANCE

The Grievance provision in this certificate may be superseded by the law of your state if you are not a Missouri resident and if such other state's Grievance provision is more favorable than that which is provided in this certificate. Please see your explanation of benefits for the applicable Grievance procedure.

WHEN YOU HAVE A COMPLAINT OR GRIEVANCE

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

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

Start with Customer Service

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

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

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

Grievance Procedure

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

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

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

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

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

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

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

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

If you request that your Grievance be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one Grievance would be detrimental to your medical condition.

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

Independent Review Procedure

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

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

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

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

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

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

Notice of Benefit Determination on Grievance
Every notice of a determination on Grievance will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary Grievance procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your Grievance, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the Grievance process. A final notice of adverse determination will include a discussion of the decision.

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

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

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

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.

Class Action Waiver: Without limiting the applicability of Missouri, You expressly waive the ability to maintain a Class Action in any arbitration proceeding.

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 grace period, however if We do not receive Your premium due in full before the end of the grace period, Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement.

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

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period for plans not purchased from a Marketplace or the 61 day grace period for plans purchased from a Marketplace.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. Cigna may cancel this Policy for the reasons stated under “Specific Causes for Ineligibility” in the section titled “Who is Eligible for Coverage” by written notice delivered to You, or mailed to Your address in Our files, at least 5 days’ advance notice of the date the Policy terminates.
6. When We cease to offer policies of this type to all individuals in Your class. In this event, Missouri 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.
7. When We cease offering any plans in the individual market in Missouri, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
8. When the Insured no longer lives in the Enrollment Area.

In the event of cancellation, We will return promptly the unearned portion of any premium paid. If the Insured Person cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata.

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

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

Modification of Coverage: We reserve the right to modify this policy, including Policy provisions, benefits and 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 make any modifications effective upon the Policy renewal date. We will send written notice and the change will become effective on the date shown in the notice or on the next scheduled premium due date thereafter. Payment of the premiums will indicate acceptance of the change.

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

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

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

There is a $45 fee for reinstatement.

Renewal: This Policy renews on a Calendar Year basis.

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

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

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

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

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

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

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

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

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

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

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

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

We will pay all benefits of this Agreement directly to Participating Hospitals, Participating Physicians, and all other Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case We will reimburse the Insured Person. In addition, We may pay any covered Provider of services directly when the Insured Person assigns benefits in writing no later than the time of filing proof of loss (claim), except for Foreign Country Provider claims. However, We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Dependent, You or Your Dependents are responsible for reimbursing the Provider and Our payment to You will be considered fulfillment of Our obligation.

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

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

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

Continuation of Care after Termination of a Provider whose participation has terminated:
Cigna will provide benefits to You or Your Insured Family 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.
- Ongoing treatment of an Insured Person who at the time of termination has been diagnosed with a terminal illness, but in no event beyond 9 months from the date of the Provider's termination date.

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

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

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

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

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

Other Insurance With This Insurer

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

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

How to File a Claim for Benefits

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

If Your provider does not submit a claim for You, written notice of claim must be given to Us within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on Your or on behalf of Your the beneficiary the claims address on Your ID card, or to any authorized agent of Cigna, with information sufficient to identify the Insured Person, shall be deemed notice to Cigna".

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

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

Cigna, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss.

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

Claim Reminders:

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

Proof of Loss:
Written proof of loss must be furnished to Us in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within ninety days after the termination of the period for which We are liable; and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required".

Proof of loss is a claim form as described above. Canceled checks or receipts are not acceptable. Cigna will not be liable for benefits if it does not receive written proof of loss within this time period.

Assignment of Claim Payments:

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

We 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. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: We may pay all or a portion of any indemnities provided for health care services to the participating health care services Provider, unless You direct otherwise in writing by the time proofs of loss are filed. We will pay all or a portion of any indemnities provided for health care services by a nonparticipating health care services Provider directly to You, unless You direct otherwise in writing by the time proofs of loss are filed. We cannot require that the services be rendered by a particular health care services Provider. In the event of Your death, We will issue any benefits payable to You to the beneficiary of Your estate. In the absence of a valid release, We may pay up to $2000 to someone whom We deem entitled.

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

Procedures Regarding Medical Necessity Determinations

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

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

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

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

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

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

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

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

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

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

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.

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

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 on 30 days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Insured Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown on the notice, and payment of the new premiums will indicate acceptance of the change.

Premiums are to be paid by You to Us.

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.