MEDICAL ENROLLMENT INFORMATION, Restrictions & Requirements

When Can I enroll for a New 2014 PPACA compliant plan?

New customers can apply during the Annual Open Enrollment Period or during the year based on certain Qualifying Events as outlined in the Special Enrollment Periods section below. Current Cigna customers have the option to change plans during Annual Open Enrollment or during a Special Enrollment Period.

Initial Open Enrollment Period

Open enrollment for 2014 is from October 1, 2013 through March 31, 2014.

Special Enrollment Periods

To apply outside of the Open Enrollment Period an applicant must experience a Qualifying (Triggering) Event and has 60 days from the date of that event, (including the date of the actual event) to apply for coverage or make a change to an existing plan. Persons who enroll during a special enrollment period will have coverage effective dates determined as follows:

(1) 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;

(2) 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.

Note that in the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. In the case of marriage or in the case where an individual loses minimum essential coverage, coverage is effective on the first day of the following month.

Qualifying (Triggering) Events

(1) An individual and any dependents losing minimum essential health coverage (or, in many cases, the expiration of other medical coverage); or

(2) Loss of employer-sponsored health plan coverage due to termination, reduction in work hours, divorce, separation, Medicare entitlement, death or loss of dependent child status; or

(3) An individual gaining or becoming a dependent through marriage, birth, adoption or placement for adoption; or

(4) An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation from his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or

(5) An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or

(6) An individual who was not previously a citizen, national or lawfully present individual gains such status (only applicable for plans sold on the Health Insurance Marketplace); or

(7) An individual experiencing an error in enrollment; or

(8) An individual adequately demonstrating that the plan or issuer substantially violated a material provision of the contract in which he or she is enrolled; or

(9) An individual becoming newly eligible or newly ineligible for advance payments of the premium tax credit or experiencing a change in eligibility for cost-sharing reductions; or

(10) New coverage becoming available to an individual or enrollee as a result of a permanent move; or

(11) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or

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change from one qualified health plan to another one time per month (only applicable to the Marketplace); or

(12) An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide (only applicable to the Marketplace).

Effective Dates

For the Initial Open Enrollment Period, the first effective date for a medical plan is January 1, 2014. Below are the effective dates for the Initial Open Enrollment Period:

Enrolling between:

- October 1st 2013 through December 15th 2013, the effective date will be January 1, 2014
- December 16th 2013 through January 15th 2014, the effective date will be February 1, 2014
- January 16th 2014 through February 15th 2014, the effective date will be March 1, 2014
- February 16th 2014 through March 15th 2014, the effective date will be April 1, 2014
- March 16th 2014 through March 31st 2014, the effective date will be May 1, 2014
- No applications for the Initial Open Enrollment Period will be accepted after March 31, 2014

Age and Dependent Requirements

All applicants applying for coverage must meet age, dependent status and residency requirements.

- Dependent children are covered up to age 26. Dependent children who have reached age 26 can continue to be covered up to the end of the calendar year in which they reach age 30 provided the child is unmarried and does not have a dependent of their own, and is a resident of Florida or a full-time or part-time student, and is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act. Your own, or spouse's children, regardless of age who are enrolled prior to age 26 and are incapable of self-support due to a medically certified continuing mental or physical disability and are dependent upon the insured for support can continue coverage with written proof of disability and dependency within 31 days after the child's 26 birthday. Cigna may require written proof of such disability or dependency thereafter.
- A newborn child or newly adopted child, born or adopted to an enrolled subscriber, may be added to the subscriber's plan within 31 days of the birth or adoption. Requests for enrollment beyond 31 days of the birth or adoption will need to wait until the next open enrollment period
- Foster children will automatically be covered for 31 days from the date of placement in the subscriber's residence. To continue coverage, the foster child must be enrolled as an insured family member by notifying Cigna within 31 days after placement and paying any additional premium. Requests for enrollment beyond 31 days of the foster placement will be subject to the full application and medical underwriting evaluation
- A child born to one of the subscriber's dependent children will be eligible for coverage from birth through 18 months of age.
- Any newborn is automatically covered for the first 31 days of life. To continue coverage, the newborn must be enrolled as an insured family member by notifying Cigna, in writing, within 31 days of the birth and paying any additional premium. Requests for enrollment beyond 31 days of the birth will need to wait until the next open enrollment period
- Foreign exchange students are not eligible dependents

Signature Requirements

All applicants and dependents 18 years and older must sign and date the application.

Residency Requirements

- Must be a citizen or national of the United States, or is a non-citizen who is lawfully present in the United States, and is reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought.
- Citizens/Expatriates who have been living and working outside the U.S. and who are in process of returning to the U.S. are eligible to apply; the requested effective date must be after their return to the U.S.
- Applicants must reside in the following Florida counties at the time of application:
  - Hernando
  - Hillsborough
  - Lee
  - Manatee
  - Pasco
  - Pinellas
  - Polk
  - Sarasota
  - Brevard
  - Flagler
  - Indian River
  - Lake
  - Orange
  - Osceola
  - Seminole
  - Sumter
  - Volusia
  - Broward
  - Martin
  - Miami-Dade
  - Monroe
  - Palm Beach
  - Saint Lucie
- Dependents are not required to share the same address as the primary policy holder.

Premium Impact

Tobacco Risk

Applicants who may legally use tobacco under federal and state law and who have used tobacco on average for four or more times per week within no longer than the past 6 months, will be assigned a 25% rate increase. Tobacco use includes all tobacco products except those used for religious or ceremonial purposes.

Health Insurance Marketplace

For health coverage purchased through the Marketplace, customers may be eligible for federal financial assistance. More information about the Marketplace can be found at **www.healthcare.gov** or calling 800.318.2596.

Post Enrollment

10-Day Free Look

After the applicant reviews the policy, if they are not satisfied for any reason, they can call Cigna at the number in their policy within 10 days. Cigna will refund any premium they've paid (including contract fees or other charges) less the cost of any services paid on their behalf or on behalf of any of their covered dependents.

Insufficient Funds Charge

The applicant is responsible for an additional charge of $45 for any check or electronic funds transfer that is returned to Cigna unpaid.

Medical Prior Authorization Requirements and Exception Process

Prior Authorization

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

Prior Authorization for Inpatient Admissions

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 or lack of coverage for services provided.** Prior authorization can be obtained by the policyholder, a family member(s) or the provider by calling the number on the back of the ID card. Inpatient prior authorization reviews both the necessity for the admission and the need for continued stay in the hospital.

Call the Member Services number on the back of the Cigna ID card or check **mycigna.com**, under "View Medical Benefit Details" for more detailed information regarding services that require prior authorization.

Emergency admissions will be reviewed post admission.

Prior Authorization for Outpatient Procedures

Certain outpatient procedures and services require review and prior authorization in order to be eligible for benefits. **Failure to obtain prior authorization for certain elective outpatient procedures and services may result in a penalty or lack of coverage for services provided.** Prior authorization can be obtained by the policy holder, family member(s) or the provider by calling the number on the back of the Cigna ID card. Outpatient prior authorization should only be requested for non-emergency procedures or services, at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Please call the Member Services number on the back of the Cigna ID card or check **mycigna.com** under "View Medical Benefit Details for more detailed information regarding services that require authorization.

Prior authorization is not a guarantee of payment. Prior authorization does not guarantee payment of benefits. Coverage is always subject to other requirements of the policy, such as limitations and exclusions, payment of premium and eligibility at the time care and services are provided.

Retrospective Review

If prior authorization was not performed, Cigna will use retrospective review to determine if a scheduled or emergency admission was medically necessary. In the event the services are determined to be medically necessary, benefits will be provided as described in the 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.

Pharmacy Formulary Prior Authorization and Exception Process Coverage of New Drugs

Prior Authorization

Coverage for certain prescription drugs and related supplies requires the physician to obtain prior authorization from Cigna before prescribing the drugs or supplies. This may include a step therapy determination to discover the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition.

Exception Process

If your physician believes non-prescription drug list prescription drug or related supplies are necessary, or want coverage for prescription drugs or related supplies for which prior authorization is needed, the physician can call or complete the prior authorization form and fax it to Cigna to request an exception for coverage of the prescription drugs or related supplies. The physician can certify in writing that the insured person has previously used an alternative non-restricted access drug or device and the alternative drug or device has been detrimental to the insured person's health or has been ineffective in treating the same condition and, in the opinion

of the prescribing physician, is likely to be detrimental to the insured person's health or ineffective in treating the condition again. The physician should make this request before writing the prescription.

If the request is approved, your physician will receive confirmation. The prior authorization will be processed in our claim system to allow you to have coverage for those prescription drugs or related supplies. The length of the prior authorization will depend on the diagnosis and prescription drugs or related supplies. When your physician advises you that coverage for the prescription drugs or related supplies has been approved, you should contact the pharmacy to fill the prescription(s).

If the request is denied, your physician and you will be notified that coverage for the prescription drugs or related supplies was not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the prescription drugs or related supplies should be covered.

Pediatric Dental Plan

When a Cigna Medical Plan is not purchased on the Health Insurance Marketplace the PPACA compliant pediatric plan is included as part of the Cigna medical plan and covers children up to age 19.

When can I enroll?

Because the dental plan is included with the medical plan, dental must follow the medical enrollment rules. As a result, new customers can apply for a medical plan during the Annual Open Enrollment Period or during the year based on certain Trigger Events as outlined in the Special Enrollment Periods section above. Current Cigna customers have the option to change plans during Annual Open Enrollment or during the Special Enrollment Period. (See the Enrollment Information, Restrictions & Requirements section above for additional information.)

Effective Dates

The effective date for a pediatric dental plan coincides with the effective date of the medical plan.

On Health Insurance Marketplace

On the Health Insurance Marketplace the plan is available for purchase independently or alongside a Cigna medical plan.

When can I enroll?

New customers can apply for a Cigna Pediatric Dental plan on the Health Insurance Marketplace during the Annual Open Enrollment Period or during the year based on certain Trigger Events as outlined in the Special Enrollment Periods section above.

Effective Dates

The first effective date for a dental plan can be January 1, 2014, or when requested on the application. Effective dates can be the first day of the following month after submitting an application, as long as it is submitted on or before the 15th of the prior month.

If you have questions about the plan, please call the number on the Cigna ID card or log on to myCigna.com for more information about the plan.

Visit www.Cigna.com/ifp-providers to review the providers considered in-network for this policy.

LocalPlus Network Information

In Florida, Cigna medical plans use the Cigna LocalPlus Network of participating health care providers which offers referral-free access to a smaller network of participating health care providers (physicians, hospitals etc.) than the larger Cigna OAP Network. To minimize your out-of-pocket expenses, visit health care providers in the LocalPlus Network. If you choose to visit a health care provider Out-of-network (OON) you will be reimbursed at the OON benefit level. The difference in the amount that Cigna reimburses for such services and the amount charged by the physician, hospital or provider except for emergency services, will also increase your OON costs.

In-network

- LocalPlus Network providers in the LocalPlus Network for this plan
- LocalPlus Network providers in other LocalPlus Network areas
- Cigna OAP Network providers in an area that is not part of the LocalPlus Network
- Any visit considered an emergency as defined by your policy

Out-of-network

- Any provider in your LocalPlus Network area that is not part of the LocalPlus Network
- Providers in other LocalPlus Network areas that are not part of the LocalPlus Network
- Non-Cigna providers in any area

For more detailed information or to find providers in the LocalPlus network, including participating providers when you are away from home, please review the LocalPlus Network flyer, visit **www.Cigna.com/ifp-providers** or call 1.800.Cigna24.

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