Cigna HealthCare of Arizona, Inc.
INDIVIDUAL AND FAMILY SERVICE AGREEMENT
Cigna Connect 0-4

IMPORTANT NOTICE

Direct Access to Obstetricians and Gynecologists (OB/GYN)

You do not need prior authorization from the plan or from any other person (including a Primary Care Physician) 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 Physician

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

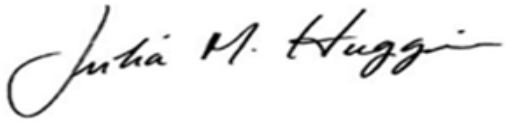
For children, You may designate a pediatrician as the Primary Care Physician.

If You wish to correspond with Us for any reason, write:

Cigna
Individual Services
P. O. Box 182223
Chattanooga, TN 37422

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

Signed for Cigna by:



Julia M. Huggins, President

Anna Krishtul, Corporate Secretary

Table of Contents

INTRODUCTION

This Service Agreement is a legal contract between You as the Subscriber, and Cigna.

Under this Agreement, “We”, “Us”, and “Our” mean Cigna. “You” or “Your” refers to the Subscriber whose application has been accepted by Us under the Agreement issued. When We use the term “Member” in this Agreement, We mean You and any eligible Dependent(s) who are covered under this Agreement.

The benefits of this Agreement are provided only for those services that are Medically Necessary as defined in this Agreement and for which the Member 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 Agreement or phone Us at the number shown on Your Cigna identification card if You have any questions regarding whether services are covered.

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

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

This Agreement may not apply when You have a claim, and please read the paragraph below carefully. This Agreement was issued to You by Cigna Healthcare of Arizona, Inc. (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 Us immediately regarding the incorrect information; otherwise, Your Agreement may not be a valid contract.

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

RIGHT TO RETURN CONTRACT

If You are not satisfied, for any reason, with the terms of this Agreement 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 Agreement will then be null and void.

SERVICE AREA RESTRICTIONS

This Agreement includes a Service Area restriction which requires that all Members receive services in the defined service area. Coverage outside of the defined Service Area is limited to Emergency Services and Emergency Medical Treatment only. The Service Area for this Agreement is anywhere within Maricopa County, AZ.

ROLE OF THE PRIMARY CARE PHYSICIAN

Establishment of the Physician-Patient Relationship

By enrolling, You are choosing to have services and benefits under the "Covered Services and Benefits Section" provided by, or arranged for by, a Primary Care Physician. The Primary Care Physician maintains the physician-patient relationship with Members who select him or her as their Primary Care Physician. The Primary Care Physician is responsible to Cigna for providing and/or coordinating Medical Services and Hospital Services for overall health care needs of such Members.

Choosing a Primary Care Physician

When You enroll as a Member, You must choose a Primary Care Physician (PCP). Each covered Member of Your Family also must choose a PCP. If You do not select a PCP, we will assign one for You. If Your PCP leaves the Cigna network, You will be able to choose a new PCP.

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

Changing Primary Care Physicians

You may voluntarily change Your PCP but not more than once in any calendar month. We reserve the right to determine the number of times during a Year that You will be allowed to change Your PCP. You may request a change from one Primary Care Physician to another by contacting Us at the Customer Service number on Your ID card. Any such change 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 Your PCP Leaves the Network

If Your Primary Care Physician 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 Primary Care Physician leaves the network and provide assistance in selecting a new Primary Care Physician or identifying a new In-Network specialist to continue providing Covered Services.

If You are receiving treatment from a Participating Physician at the time his or her Participating Physician agreement is terminated, for reasons other than medical incompetence or professional misconduct, You may be eligible for continued care with that Provider.

Continuity of Care

If Your Primary Care Physician 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 not more than 30 days after the date of either Your enrollment or the date Your treating Physician ceased to be a Participating Physician, 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, for services related to the delivery up to 6 weeks after the delivery.

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 earliest 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.

Referrals to Specialists

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

Exceptions to the Referral process:

If You are a female Member, You may visit a qualified Participating Physician for covered obstetrical and gynecological services, as defined in “Covered Services," without a Referral from Your PCP. You do not need a Primary Care Physician Referral for Virtual visits with a Cigna Telehealth Connection Physician.

If You are a Member under age 19, You may visit a Network Dentist for Pediatric Dental Benefits or a Physician in Cigna's vision network for Pediatric Vision Benefits without a Referral from Your PCP.

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

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

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

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

Standing Referral to Specialist

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

1. You are a covered Member of the Cigna HMO Agreement;
2. You have a disease or condition that is life threatening, degenerative, chronic or disabling;
3. Your PCP in conjunction with a network specialist determines that Your care requires another Physician expertise;
4. Your PCP determines that Your disease or condition will require ongoing medical care for an extended period of time;
5. The standing Referral is made by Your PCP to a network specialist who will be responsible for providing and coordinating Your specialty care; and
6. The network specialist is authorized by Cigna to provide the services under the standing Referral.

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

Special Circumstances

This Agreement does not cover expenses incurred for services provided by Non-Participating Providers except in the limited situations described below. Your cost-sharing for Covered Expenses incurred for the services of a Non-Participating Provider in these special circumstances is indicated in the Benefit Schedule.

Please be aware that Non-Participating Providers may balance bill you for any amounts over the Maximum Reimbursable Charge as described in the Definitions section of this Agreement.

Emergency Services

Covered Expenses incurred for the treatment of an Emergency Medical Condition provided in the emergency department of a Non-Participating Hospital are covered as described in the benefits Schedule. Any expenses incurred for services of a Non-Participating Provider after the patient is Stabilized and his/her condition permits transfer to a Participating Hospital and/or to the care of a Participating Physician are not covered.

Other Circumstances, Network Exception

Covered Expenses for non-Emergency, Medically Necessary services of a Non-Participating Provider will be paid according to the Participating Provider Cost Share shown in the Benefit Schedule in the following cases:

- when those services are unavailable from a Participating Provider, or
- for any other reason We determine it is in Your best interests to receive services from a Non-Participating Provider.

DEFINITIONS

90day 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. a 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 Member in determining whether to make such payments on Your behalf.
Agreement	means the Cigna HealthCare of Arizona, Inc. Individual Plan Service Agreement document, the Benefit Schedule, any Supplemental Riders and any other attachments described herein, the Enrollment Application, and any subsequent amendment or modification to any part of the Agreement.
Annual, Calendar Year, Year	means 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 any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association: Autistic Disorder, Asperger's Syndrome, and Pervasive Developmental Disorder - Not Otherwise Specified.
Benefit Schedule	the part of this Agreement that identifies applicable Copayments, Coinsurance, Deductibles, and maximums.
Birthing Center	means a licensed outpatient facility which provides accommodations for childbirth for low-risk maternity patients. The Birthing Center must meet all of the following criteria: 1. Has an organized staff of certified midwives, Physicians, and other trained personnel; 2. has necessary medical equipment; 3. Has a written agreement to transfer to a hospital if necessary; and 4. Is in compliance with any applicable state or local regulations.
Brace	is an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.
Brand Name Prescription Drug (Brand Name)	means a Prescription Drug that has been patented and is produced by only one manufacturer.
Business Decision Team	is a committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to make recommendations regarding coverage treatment of Prescription Drugs and Related Supplies based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to Prescription Drugs and Related Supplies.
Charges	means the actual billed Charges; except when the Physician has contracted directly or indirectly with Cigna for a different amount.
Cigna	means Cigna HealthCare of Arizona, Inc. a health maintenance organization (HMO) which is organized under the laws of the State of Arizona. Cigna is a party to the Agreement.
Cigna LifeSOURCE Transplant Facility	is a facility with a transplant program that is included in the Cigna LifeSOURCE Transplant Network®.
Cigna Medical Director	means a Physician or his designee charged with the direction and management of Participating Physicians.

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 Member 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 Agreement network, and is only available for services detailed under "Cigna Telehealth Connection" in the "Covered Services and Benefits" section of this Agreement.
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 Agreement.**
Copayment	means a predetermined fee for physician office visits, prescriptions, hospital or other services that the Member pays at the time of service.
Cosmetic Surgery	means surgery that 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.**
Cost Share	is the Deductible, Copayment and Coinsurance amounts You are responsible to pay under the Agreement.
Covered Expenses	means the expenses incurred for Covered Services which Cigna will consider for payment under this Agreement. Covered Expenses are: ▪ The Negotiated Rate for Covered Services from Participating Providers. ▪ The Maximum Reimbursable Charge for Covered Services from Non-Participating Providers. Covered Expenses may also be limited by other specific maximums or terms described in this Agreement. Covered Expenses are subject to any applicable Deductibles and other benefit limits. An expense is incurred on the date the Member receives the service or supply. Covered Expenses may be less than the amount that is actually billed.
Covered Services	means Medically Necessary services or supplies that: (a) are listed in the benefit sections of this Agreement, and

	(b) are not specifically excluded by the Agreement; 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/ Custodial Services	means any service that is of a sheltering, protective or safeguarding nature. Such services 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 means medical services given primarily to maintain a person's current state of health. These services cannot be intended to 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 walking, grooming, bathing, dressing, getting in or out of bed, eating, preparing foods taking medications that can be self-administered); and • services not required to be performed by trained or skilled medical or paramedical personnel.
Days	mean calendar days unless expressly stated otherwise.
Deductible	means the amount of Covered Expenses each Member must pay for Covered Services each Year before benefits are available under this Agreement.
Dental Prostheses	are dentures, crowns, caps, bridges, clasps, habit appliances, and partials.
Dependent	means those individuals in the Subscriber's family who meet the eligibility requirements of the "Dependent" provision of the "Eligibility" Section and are enrolled under the Agreement.

Diabetes Equipment	includes, but is not limited to, blood glucose monitors, including monitors and drawing up devices designed to be used by blind and/or visually impaired persons; insulin pumps and associated appurtenances, including insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices in the injection of insulin and any other required disposable supplies; podiatric appliances for the prevention of complications associated with diabetes; the repair or maintenance of insulin pumps not covered under a manufacturer's warranty and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.
Diabetes Pharmaceuticals & Supplies	include, but are not limited to, insulin preparations and glucagon, blood glucose monitors on Cigna's Prescription Drug List and test strips for blood glucose monitors; specific blood glucose monitors; visual reading and urine test strips; tablets that test for glucose, ketones and protein; lancets and lancet devices; insulin and insulin analogs; injection aids, including devices used to assist with insulin injection and needleless 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	means 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 ordered or prescribed 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	means the date on which coverage under this Agreement begins for You and any of Your Dependent(s).
Emergency Medical Condition	means a medical or behavioral 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. respect to a pregnant woman placing the health of the woman or unborn child in serious jeopardy; or with respect to a pregnant woman having contractions, that there is inadequate time to effect a safe transfer to another hospital for delivery; or to Stabilize the medical condition of a pregnant woman; 3. serious impairment to bodily functions; 4. serious dysfunction of any bodily organ or part; or 5. serious behavioral health condition that places health of insured or others in serious jeopardy.
Emergency Services	means, with respect to an Emergency Medical Condition: (a) a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.
Essential Health Benefits	means, to the extent covered under this Agreement, 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/ Unproven Procedures	a drug, device or medical treatment or procedure is considered Experimental or Investigational or Unproven 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 trial or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the current standard of treatment or diagnosis; ▪ or reliable evidence shows that the consensus of 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 standard means of treatment of diagnosis.

	Reliable evidence means only; the published reports and articles in authoritative, peer-reviewed 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 Agreement. It is an accumulation of the Individual Deductible paid by each Family Member for Covered Expenses for medical and Prescription Drug Covered Services during a Year. Each Member can contribute up to the Individual Deductible amount toward 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 Benefit Schedule.
Family	means the group of individuals consisting of a Subscriber and his or her Dependents who are enrolled for coverage under this Agreement. Family Member refers to any one of these individuals.
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 Agreement. It is an accumulation of the Deductible, Coinsurance and Copayments each Family Member has accrued during a Year. Each Member 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 Benefit Schedule section of this Agreement.
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 Center	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 or Drugs, as the case may be.
Habilitative Services	means health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Home Health Agencies and Visiting Nurse Associations	are home health care Providers that are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in Your home. They must be approved as home health care providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.
Hospice Care Program	means a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families; a program that provides palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness; and 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 Participating Hospital, (b) a participating skilled nursing facility or a similar institution, (c) a participating home health care agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program, which is a participating Medicare-approved Hospice Care Program.
Hospice Facility	means a participating institution or part of it which primarily provides care for Terminally Ill patients; is a Medicare-approved hospice care facility; meets standards established by Cigna; and fulfills all licensing requirements of the state or locality in which it operates.
Hospital	means: • an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses; or • an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a Provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission

	on the Accreditation of Healthcare Organizations; or • an institution which: (a) specializes in treatment of mental health and substance use disorder or other related Illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency. The term Hospital will not include any institution or facility in which a significant portion of the activities include rest, recreation, leisure, or any other services that do not consist exclusively of Covered Services.
Hospital Services	means, except as limited or excluded by the Agreement, services for registered bed patients or outpatients which are customarily provided by acute care Hospitals and which are authorized by Cigna as specified in the "Services and Benefits" Section.
Illness	is a sickness, disease, or condition of a Member.
Individual Deductible	means the amount of Covered Expenses incurred from Participating Physicians, for medical and Prescription Drug Covered Services, that You must pay each Year before any benefits are available. The amount of the Individual Deductible is described in the Benefit Schedule.
Individual Out -of -Pocket Maximum	The Individual Out-of-Pocket Maximum is an accumulation of Covered Expenses. It includes Deductibles, Copayments and Coinsurance for medical and Prescription Drug Covered 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 Benefit Schedule section of this Agreement.
Infusion and Injectable Specialty Prescription Medications	means 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 supplies, enzyme replacements and intravenous immunoglobulin. Such Specialty Medications may require Prior Authorization or precertification.
Injury	means an accidental bodily injury.
Institution	means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor as defined by Federal law and regulations specifically 42 CFR § 435.403(b), 42 CFR § 435.1010, 45 CFR § 155.305, and 45 CFR 1355.20.

Limited Distribution Drugs (LDDs)	are drugs with special requirements used to treat conditions affecting only a small percentage of the population. Because of this, the manufacturer may choose to limit the distribution of the drug to only a few pharmacies, or as recommended by the Food and Drug Administration (FDA) for the drug as a condition of its approval of the drug. This type of restricted distribution helps the manufacturer to monitor the inventory of the drug, educate the dispensing pharmacists about the required necessary monitoring, and ensure that any associated risks are minimized.
Marketplace	means a state-based Marketplace, a state partnership Marketplace, or a federally-facilitated Marketplace, as the case may be.
Maximum Reimbursable Charge	is the amount that Cigna will consider Covered Expense for a Non-Participating Provider. Cigna calculates the Maximum Reimbursable Charge as follows: ▪ **For Covered Expenses for Emergency Services performed by a Non-Participating Provider in the Emergency Department of a Hospital or Emergency Services delivered in the Emergency Department of a Non-Participating Hospital or facility,** the amount agreed to by the Non-Participating Provider or Hospital and Cigna or, if no amount is agreed to, **the greatest of**: o The median amount negotiated with Participating/In-Network Cigna Providers for the same services, or o The maximum amount Cigna would pay for a non-Emergency Out-of-Network Provider, or o The amount payable under the Medicare program, not to exceed the Non-Participating Provider's billed charges. ▪ **For Covered Expenses for non-Emergency Services, the lesser of**: o The Provider's normal charge for a similar service or supply; or o 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.
Medical Services	means, except as limited or excluded by the Agreement, those professional services of Physicians or Other Participating Health Professionals, including medical, surgical, diagnostic, therapeutic, and preventive services authorized by Cigna as specified in the "Services and Benefits" Section.
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. ▪ Not primarily for the convenience of any Member, Physician, or another Provider. ▪ Within generally accepted standards of good medical or dental practice within the community of qualified professionals. ▪ Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting. ▪ The most appropriate procedure, supply, equipment or service which can be safely provided and that satisfies the following requirements: i) Must have been proven by scientific studies published in peer-reviewed medical literature to be associated with beneficial health outcomes, demonstrating that the expected health benefits are clinically significant and produce a greater likelihood of benefits, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and ii) Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and iii) For hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The fact that a Provider prescribed, ordered, recommended or approved a service, supply, treatment or Confinement does not in and of itself make it Medically Necessary or Dentally Necessary or a Medical or Dental Necessity.
Medicare	the term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.
Medication Synchronization	means the coordination of medication refills for a patient taking two or more medications for a chronic condition that are being dispensed by a single contracted Pharmacy to facilitate the synchronization of the patient's medications for the purpose of improving medication adherence This policy will prorate the cost sharing rate for a Prescription Drug that is dispensed for less than the standard refill amount if the insured requests: • enrollment into a Medication Synchronization program; and • less than the standard refill amount for the purpose of synchronizing the insured's medications.
Member	means an individual enrolled under this Agreement who is entitled to receive services and benefits hereunder, including the Subscriber and his or her Dependent(s).

Mental Health Services	means services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes; these include, but are not limited to: neurosis, psychoneurosis, psychopathy, and psychosis.
Negotiated Rate	is the lesser of billed charges or the rate of payment that has been negotiated with a Participating Provider for Covered Services.
Network Specialist	means a specialty-practice Physician who is part of the Agreement's HMO Participating Provider Network at the time services are rendered.
Newborn	is an infant within 31 days of birth.
Non-Participating (Out-of-Network) Pharmacy	is a retail Pharmacy which Cigna has NOT contracted with to provide Prescription Drug services to Members; or a home delivery with which Cigna has NOT contracted to provide mail-order prescription services to Members.
Non-Participating Provider (Out-of-Network)	is a provider who does not have a Participating Provider agreement in effect with Cigna for this Agreement at the time services are rendered.
Orthoses and orthotic devices	means orthopedic appliances or apparatuses used to support, align, prevent or correct deformities.
Other Participating (In-Network) Health Care Facility	means any facility other than a Participating Hospital or Hospice Facility which is operated by or has an agreement with Cigna to render services to Members. Other Participating Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals, and sub-acute facilities. Other Participating (In-Network) Health Care Facilities do NOT include long-term care facilities, residential facilities, care homes, rest homes, or assisted living facilities.
Other Participating (In-Network) Health Care Professional	means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver Medical Services and who has an agreement with Cigna to render services to Members. Other Participating Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.
Out–of-Pocket Maximum	means the maximum amount of Deductible, Copayment and Coinsurance each Individual or Family incurs in Covered Expenses from Participating Providers and, in case of network exceptions, any Non-Participating Providers in a Year.
Participating (In-Network) Hospital	means an institution that is licensed as an acute care hospital under applicable state law, which has an agreement with Cigna to provide Hospital Services to Members.
Participating (In-Network) Pharmacy	means a retail pharmacy with which Cigna has contracted to provide Prescription Drug services to Members; or a designated mail-order pharmacy with which Cigna has contracted to provide mail-order prescription services to Members.

Participating (In-Network) Physician	means a Primary Care Physician (PCP) or other Physician who has an agreement with Cigna to provide Medical Services to Members.
Participating (In-Network) Provider	means Participating Hospitals, Participating Physicians, Other Participating Health Care Professionals, and Other Participating Health Care Facilities which are: 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, and have contracted with Cigna to provide services to Members.
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 Member resides; and provides services covered by the Agreement that are within the scope of his or her licensure.
Patient Protection and Affordable Care Act of 2010 (PPACA)	means 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).
Pharmacy	means a retail Pharmacy or a home delivery Pharmacy.
Pharmacy & Therapeutics (P&T) Committee	is a committee comprised of both voting and non-voting Cigna employed clinicians, medical directors and pharmacy directors and non-employees such as Participating Providers that represent a range of clinical specialties. Consistent with applicable regulatory requirements, the P&T Committee regularly reviews Prescription Drugs and Related Supplies, including new Prescription Drugs and Related Supplies, for safety and efficacy; the findings of these clinical reviews enable the Business Decision Team to make coverage status recommendations. The P&T Committee's review may be based on the U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.
Plan Year	means the year commencing on January 1 and ending on December 31 unless otherwise defined in Your new Member kit or annual renewal notification.
Premium	means the sum of money paid periodically to Cigna by You in order for You and your Dependents to receive the services and benefits covered by the Agreement.
Prescription Drug	means: • 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	means 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 and the Business Decision Team. The Prescription Drug List is regularly reviewed and updated. You can view the drug list on www.myCigna.com
Prescription Order	means a 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.
Prostheses/Prosthetic Appliances and Devices	are 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.
Prevailing Rate	means the usual and customary amount that Participating Providers charge self-pay patients for services not covered under this Agreement
Primary Care Physician/Primary Care Provider(PCP)	means a Participating Physician engaged in general practice, family practice, internal medicine or pediatrics who, through an agreement with Cigna, provides basic health services to and arranges specialized services for those Members who select him/her as their Primary Care Physician.
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's Medical Director 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 Agreement. You can identify the Prescription Drugs and Related Supplies that require Prior Authorization on the Prescription Drug List at www.myCigna.com/ifp-drug-list.
Priority Review	is an FDA classification for drugs where significant improvement is expected compared to marketed products, in the treatment, diagnosis, or prevention of a disease.

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	means 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 Agreement, breast reconstruction means reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.
Referral	the approval You must receive from Your PCP in order for the services of a Participating Physician, other than the PCP, participating Obstetrician/Gynecologists, Chiropractic Physician, pediatric dental provider or participating vision care Physician to be covered.
Rehabilitative Therapy	means, except as limited or excluded by the Agreement, treatment modalities which are part of a rehabilitation program, including physical therapy, speech therapy and occupational therapy.
Related Supplies	means 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)and disposable needles and syringes needed for injecting covered drugs and supplements.
Self-administered Injectable Drugs	are 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 Member.
Service Area	is any place that is within the cities, counties and/or zip code areas in the state of Arizona that Cigna has designated as the Service Area for this Agreement, as described in the Provider Directory applicable to this Agreement. For specific information regarding Your Service Area, please check the Provider Directory at www.cigna.com or call the number on the back of your ID card.

Skilled Nursing Facility	means an institution that provides continuous skilled nursing services. It must: ▪ be an institution licensed and operated pursuant to state law; ▪ be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician; ▪ 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 counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling); and certain Food and Drug Administration (FDA)-approved tobacco cessation medications (including prescription medications and over-the-counter medications with a Physician's prescription); please see the No Cost Preventive Care Drug List on www.mycigna.com for details).
Special Care Units	means special areas of a Hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.
Specialty Medication	is a Prescription Drug or medical pharmaceutical considered by Cigna to be a Specialty Medication based on the following factors, subject to applicable law: ▪ the Prescription Drug or medical pharmaceutical is prescribed and used for the treatment of complex, chronic or rare conditions, and ▪ the Prescription Drug or medical pharmaceutical has a high acquisition cost; and: ○ the Prescription Drug or medical pharmaceutical is subject to limited or restricted distribution, ○ requires special handling ○ and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Medication may not possess all or most of the above listed characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug or medical pharmaceutical will be considered a Specialty Medication. 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 Prescription Drug benefit or medical benefit of this Agreement.
Splint	a splint is an appliance for preventing movement of joints or for the fixation of displaced or movable parts.
Stabilize	means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.
Step Therapy	is a type of Prior Authorization. Cigna may require a Member to follow certain steps before covering some Prescription Drugs and Related supplies, including Specialty Medications. Cigna may also require a Member 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 Member. The Prescription Drugs and Related Supplies that require Step Therapy can be identified on the Prescription Drug List at www.myCigna.com.
Subscriber	means an individual who meets the eligibility requirements of the "Subscriber" provision of the "Eligibility" Section and enrolls under the Agreement. The Subscriber is a party to the Agreement. Also referred to as "You" or "Your".
Substance Use Disorder	disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment.
Supplemental Rider	means an addendum to this Agreement between Subscriber and Cigna.
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.
Terminal Illness/ Terminally Ill	means an illness of a Member which has been diagnosed by a Physician and for which the Member has a prognosis of six months or less to live.
Urgent Care	means medical, surgical, hospital and related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or are scheduled to receive services. Such care includes but is not limited to: dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that you should not travel due to any medical

	condition.
Usual and Customary	means a percentile or percentage of charges made by Providers of such service or supply in the geographic area where it is received as compiled in a nationally-recognized database that uses generally accepted industry standards and practices for determining the customary and reasonable billed charge for a service, and that fairly and accurately reflects the market rate.
Virtual	with respect to Cigna Telehealth Connection, means Covered Services that are delivered via secure telecommunications technologies, including telephones and internet.
We/Us/Our	Cigna HealthCare of Arizona, Inc.
You, Your, and Yourself	means the Subscriber who has applied for, and been accepted for coverage, as a party to this Agreement and is named as the Subscriber on the Agreement specification page.

ELIGIBILITY

To be eligible for Covered Services You must be enrolled as a Member. To be eligible to enroll as a Member You must meet either the Subscriber or Dependent eligibility criteria listed below.

This Agreement is for residents of the state of Arizona. The Subscriber must notify Us of all changes that may affect any Member's eligibility under this Agreement.

Subscriber

To be eligible to enroll as a Subscriber, You must:

- Be 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
- Be a resident of the state of Arizona;
- Live within the Service Area of this Agreement, and
- Not be incarcerated other than incarceration pending the disposition of charges; and
- Not reside in an Institution; and
- Submit a completed and signed application for coverage and have been accepted in writing by Us.

Dependent

To be eligible to enroll as a Dependent, a person must be:

- The Subscriber's lawful spouse or
- A child of the subscriber by birth, adoption, or foster care and has not yet reached age 26; or
- A stepchild of the Subscriber and has not yet reached age 26; or
- The Subscriber's or the Subscriber's spouse's unmarried children, regardless of age, who are incapable of self-support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday.
- The Subscriber's or the Subscriber's 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 a dependent Member by applying for his or her enrollment as a dependent within 60 days of the date of birth, and pay any additional premium. 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 a dependent Member by applying for his or her enrollment as a dependent within 60 days of the date of adoption, and pay any additional premium. 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 a Subscriber 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 a dependent Member by applying for his or her enrollment as a dependent within 60 days of the court order date, and paying 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.

NOTE: A child eligible to enroll as a Dependent under this Agreement who resides outside of the Service Area, is entitled to receive, while outside the Service Area, only out-of-area emergency benefits under the "Emergency Services" provision of the "Covered Services and Benefits" section.

When Can I Apply?

Application to Enroll or Change Coverage
The Patient Protection and Affordable Care Act of 2010 (PPACA) specifies that an eligible person must enroll for coverage or change plans during the Annual Open Enrollment Period. Persons who fail to enroll or change plans during the Open Enrollment Period must wait until the next Open Enrollment Period to enroll in a plan or to change plans. However, if a person experiences a triggering event as described below, the triggering event starts a 60-day Special Enrollment Period during which an eligible person can enroll and a Subscriber 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 Agreement, You must submit a completed and signed application for coverage under this Agreement for Yourself and any eligible Dependent(s), and We must receive that application during the Annual Open Enrollment Period.

Your coverage under this Agreement 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 enrolled in a qualified health plan, as defined by PPACA, 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;
- 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 the advanced premium tax credit (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, a Member **will become ineligible for coverage** under the Agreement:

- When premiums are not paid according to the due dates and grace periods described in the Premium Section;
- For a spouse, when the spouse is no longer married to the Subscriber;
- For You and Your Family Member(s) when You no longer meet the requirements listed in the Eligibility section;
- The date the Agreement terminates; or
- When the Member no longer lives in the Service Area. This does not apply to a dependent child living outside of the Service Area.

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

Continuation

If an Member's eligibility under this Agreement would terminate due to the Subscriber's death, divorce or if other Member(s) would become ineligible due to age or no longer qualifying as Dependents for coverage under this Agreement, except for the Subscriber's failure to pay premium, the Member has the right to continue his or her coverage, and the coverage of any eligible dependent child under this Agreement if the Member notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Agreement would otherwise terminate. Coverage will continue without evidence of insurability.

Duplicate Enrollment

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

Effective Date Of Coverage

Subject to the provisions of this Agreement, including payment of applicable Premiums in accordance with the "Payments" Section of this Agreement Your coverage will become effective at 12:01 a.m. on the first day of the month following compliance with the eligibility and enrollment requirements of, and acceptance by Cigna. Your Dependent shall have the same effective date as You, unless his or her dependent status is established after such date.

Confined to a Hospital

If You are confined in a Hospital on the effective date of Your coverage, You must notify us of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter. When You become a Cigna Member, You agree to permit Cigna to assume direct coordination of Your health care. We reserve the right to transfer You to the care of a Participating Physician and/or Participating Hospital if the Cigna Medical Director, in consultation with Your attending Physician, determines that it is medically safe to do so.

If You are hospitalized on the effective date of coverage and You fail to notify us of this hospitalization within two (2) days, or as soon as reasonably possible thereafter, refuse to permit us to coordinate Your care, or refuse to be transferred to the care of a Participating Physician or Participating Hospital, We will not be obligated to pay for any medical or Hospital expenses that are related to Your hospitalization following the first two (2) days after Your coverage begins.

PAYMENTS

Premiums and Grace Period for Members

You must remit the amounts specified by Cigna, to Cigna pursuant to this Agreement, for the applicable period of coverage on or before the first day of each such period of coverage.

If You did not purchase Your Agreement from a Marketplace, or You purchased Your Agreement from a Marketplace but did not elect to receive advanced premium tax credit, there is a grace period of 10 days during which any Premium due after the first Premium may be paid without loss of coverage. Coverage will continue during the grace period. 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 date for which You have paid Premiums.

If You purchased Your Agreement from a Marketplace and You have elected to receive advanced premium tax credit, there is a grace period of ninety (90) days during which the Premiums may be paid without loss of coverage. Coverage will continue during the grace period; however claims for services rendered after the first 30 days of the grace period will be either pended or denied until such time as your Premium is paid. 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 the provisions titled "Cancellation" and "Reinstatement" for further information regarding cancellation and reinstatement. In no event shall Cigna have any obligation to provide a reminder notice for Premiums which are not received prior to the expiration of the grace period. Only Members for whom the payments are actually received by Cigna shall be entitled to health care services hereunder, and then only for the period for which payment is received.

Cancellation:

We may cancel this Evidence of Coverage 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 applicable grace period
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 intentional misrepresentation of material fact in connection with this Plan or coverage.
5. When We cease to offer Plans of this type to all individuals in the individual market. In this event, Arizona law requires that we do the following: (1) provide written notice to each Member of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; (2) offer to each Member on a guaranteed issue basis the option to purchase any individual health insurance coverage offered by Cigna at the time of discontinuation; and (3) act uniformly without regard to any health status related factors of a Member.
6. When We cease offering any plans in the individual market in Arizona, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. When the Insured no longer lives in the Service Area. This does not apply to a dependent child living outside of the Service Area.

8. In the event of entry of a final judgment by a court declaring all or part of the Patient Protection and Affordable Care Act (P.L. 111-148) invalid, unconstitutional, or otherwise ineffective and the State not providing alternative and sufficient means of funding advanced-premium tax credits, this Agreement shall be subject to cancellation consistent with applicable federal and state law.

Reinstatement and Payment of Unpaid Premium Due:

If this Agreement cancels because You did not pay Your premium within the time granted You for payment, You may apply for reinstatement of coverage under this Agreement. You may be required to submit documentation supporting your reinstatement request prior to approval.

If this Agreement is reinstated to the original effective date, You and Cigna shall have the same rights as existed under the Agreement immediately before the due date of the defaulted premium, subject to any amendments or endorsements attached to the reinstated Agreement.

If payment of past due premium is required in connection with the reinstatement of Your coverage, payments will be applied to a period for which You have not previously paid premium in the prior 12-month period of coverage.

Member Payments

You are required to pay all Copayments and Member Coinsurance for services rendered. Copayments and Coinsurance are subject to change from time to time. You are liable for all Copayments and Coinsurance incurred by Yourself and any of Your Dependents. See Your Benefit Schedule for further detail.

The monthly Premium amount is listed on the Agreement specification page which was sent with this Agreement.

You will be responsible for an additional $45 charge for any check or electronic funds transfer that is returned to Us unpaid. This additional charge is part of your Premium obligation**.** You will not be considered to have paid Your Premium until Your Premium amount and any additional charge**s** incurred by You are received by Cigna.

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
d. Application of any additional charges as a result of a late or returned payment

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 and after prior written notice to the subscriber and consistent with federal and state law. 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 Dependents or an Acceptable Third Party Payor, except as expressly permitted by Cigna in writing. Cigna may request and upon request, You shall provide, a certified statement from You that You are not receiving payment or other remuneration from anyone other than an Acceptable Third-Party Payor as defined above for the partial or full payment of Your premium or other cost-sharing obligations under this Agreement.

COVERED SERVICES AND BENEFITS

Members are entitled to receive the Covered Services and benefits set forth in this Section, subject to payment of Copayments, Coinsurance and any applicable Deductible as specified in the Benefit Schedule, and subject to the conditions, limitations and exclusions of this Agreement.

AS SET FORTH IN THIS SECTION. SERVICES FROM NON-PARTICIPATING PHYSICIANS ARE NOT COVERED EXCEPT AS DESCRIBED IN THE EMERGENCY SERVICES PROVISION OF THE COVERED SERVICES AND BENEFITS SECTION OR WITH THE PRIOR WRITTEN APPROVAL OF THE CIGNA MEDICAL DIRECTOR.

Prior Authorization Requirements

UNLESS PRIOR WRITTEN APPROVAL OF THE CIGNA MEDICAL DIRECTOR IS RECEIVED, SERVICES AND BENEFITS SET FORTH BELOW ARE AVAILABLE ONLY IF MEDICALLY NECESSARY, RENDERED BY PARTICIPATING PHYSICIANS, AND EITHER PROVIDED OR AUTHORIZED IN WRITING BY THE MEMBER'S PRIMARY CARE PHYSICIAN.

Services that require Prior Authorization include, but are not limited to, inpatient hospital services, inpatient services at any other participating healthcare facility, outpatient facility services, advanced radiological imaging, and Transplant Services.
Prior Authorization or Step Therapy is also required for prescription drugs and Related Supplies. For more information, please refer to "Prescription Drug Benefits" in this Agreement.

PRIOR WRITTEN AUTHORIZATION IS NOT REQUIRED FOR EMERGENCY SERVICES, OBSTETRICAL AND GYNECOLOGICAL SERVICES"AND "PEDIATRIC VISION**.**

The Covered Services for which benefits are provided under this Agreement are limited to the most cost effective~~,~~ and clinically appropriate treatment, supply, or service as defined by Cigna.

Physician Services

Coverage is provided for all diagnostic and treatment services provided by Participating Physicians and Other Participating Health Professionals, including office visits, periodic health assessments, preventive care, including well-child care and routine immunizations provided in accordance with accepted medical practices, hospital care, consultation, and surgical procedures. Multiple or bilateral surgical procedures performed by one or more qualified physicians during the same operative session are covered.

Second Surgical Opinion

Following a recommendation for elective surgery, this Agreement covers one consultation and related diagnostic service by a physician. If requested, benefits will be provided for an additional consultation when the need for surgery, in your opinion, is not resolved by the first consultation.

Outpatient Services

Coverage is provided for services provided on an outpatient basis, including: diagnostic and/or treatment services; administered drugs, medications, fluids, biologicals, blood and blood products; inhalation therapy; radiation therapy, chemotherapy and hemodialysis treatment, spinal manipulation therapy, and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, and recovery room services.

Inpatient Hospital Services

Coverage is provided for inpatient Hospital services for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in an Other Participating Health Care Facility. Inpatient Hospital services include semi-private room and board; care and services in an intensive care unit; drugs, medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; laboratory and radiology services and other diagnostic and therapeutic services; anesthesia and associated services; inhalation therapy; radiation therapy; admit kit, and other services which are customarily provided in acute care hospitals. Inpatient Hospital services also include Birthing Center.

Inpatient Services at Other Participating Health Care Facilities

For any eligible condition that is Authorized by Cigna, this Agreement provides indicated benefits for Covered Expenses for inpatient services and supplies provided by an Other Participating Health Care Facility, except private room charges above the prevailing two-bed room rate of the facility. Payment of benefits for Other Participating Health Care Facility services is subject to all of the following conditions:

- The Member must be referred to the Other Participating Health Care Facility by a Physician.
- Services must be those which are regularly provided and billed by an Other Participating Health Care 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, subject to any maximum number of covered days per Year shown in the Benefit Schedule.
- Services covered under this benefit cannot be provided in a less intense setting, such as outpatient services provided at home.
- The Member must remain under the active medical supervision of a Physician treating the Illness or Injury for which he or she is confined in the Other Participating Health Care Facility.

Note: No benefits will be provided for:

- Personal items, such as TV, radio, guest trays, etc.

Emergency Services and Urgent Care

Emergency Services Both In and Out of the Service Area. In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call

911 or your local emergency service, police or fire department for help. You do not need a Referral for Emergency Services, but you do need to call your Primary Care Physician or the Cigna HealthCare 24-Hour Health Information Line SM as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your Primary Care Physician or the Cigna HealthCare 24-Hour Health Information Line SM will coordinate such care or admission and handle the necessary authorizations for care or admission. Participating Physicians are on call twenty-four (24) hours per day, seven (7) days per week, to assist you when you need Emergency Services.
If you receive Emergency Services outside the Service Area, you must notify us as soon as reasonably possible. We may arrange to have you transferred to a Participating Physician for continuing or follow-up care if it is determined to be medically safe to do so.

Urgent Care Inside the Service Area. For Urgent Care inside the Service Area, you must take all reasonable steps to contact the Cigna HealthCare 24-Hour Health Information Line SM or your Primary Care Physician for direction and you must receive care from a Participating Physician, unless otherwise authorized by your PCP or Cigna.

Urgent Care Outside the Service Area. In the event you need Urgent Care while outside the Service Area, you should, whenever possible, contact the Cigna HealthCare 24 Hour Health Information Line SM or your Primary Care Physician for direction and authorization prior to receiving services.

Continuing or Follow-up Treatment. Continuing or follow-up treatment is not covered unless it is provided or arranged for by your Primary Care Physician, a Participating Physician or upon Prior Authorization of the Cigna Medical Director.

Notification, Proof of a Claim, and Payment. Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and authorization by the Cigna Medical Director. Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than within forty-eight (48) hours of admission. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided that notification is given to us as soon as reasonably possible.
If you receive Emergency Services or Urgent Care from non-Participating Physicians, you must submit a claim to us no later than sixty (60) days after the first service is provided. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided you submit the claim and the itemized statement to us as soon as reasonably possible. Coverage for Emergency Services and Urgent Care received through Non-Participating (Out-of-Network) Physicians shall be limited to covered services to which you would have been entitled under this Agreement, and you will be reimbursed for only the costs that you incur which you would not have incurred if you received the services from a Participating (In-Network) Physician. We will pay any benefits due on a claim within 30 days of the date We receive acceptable proof of loss and all information necessary to process the claim.

REMAINDER OF SERVICES ARE LISTED IN ALPHABETICAL ORDER

Ambulance Service

Ambulance services are covered to and from the nearest appropriate Provider or facility for treatment of a Medical Emergency. Your PCP or the Cigna Medical Director must provide authorization for non-emergency ambulance services.

Autism Spectrum Disorders

Treatment for Autism Spectrum Disorders shall include the following care prescribed, provided, or ordered for an individual diagnosed with an Autism Spectrum Disorder by:

1) Physician licensed to practice medicine or
2) a certified, registered, or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a Physician licensed to practice medicine:
    a) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
    b) Psychological care, meaning direct or consultative services provided by a licensed psychologist.
    c) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.

    Applied Behavioral 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.
3) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:
    a) self-care and feeding,
    b) pragmatic, receptive, and expressive language,
    c) cognitive functioning,
    d) applied behavior analysis, intervention, and modification,
    e) motor planning, and
    f) sensory processing.

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

Bariatric Services

This Policy provides benefits for the following bariatric surgery procedures:

- open roux-en-y gastric bypass (RYGBP),
- laparoscopic roux-en-y gastric bypass (RYGBP),
- laparoscopic adjustable gastric banding (LAGB),
- open biliopancreatic diversion with duodenal switch (BPD/DS), and
-
- laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS);
- laparoscopic sleeve gastrectomy (LSG).

Only if Member:

- is 18 years or older or has reached full expected skeletal growth,
- has a body-mass index (BMI) ≥35,
- has at least one co-morbidity related to obesity, and
- had previously unsuccessful with medical treatment for obesity.

In addition, the Member's medical record must document:

- active participation within the last two years in one physician–supervised weight-management program for a minimum of six months without significant gaps. The weight-management program must include monthly documentation of all of the following components:
- weight,
- current dietary program, and
- physical activity (e.g., exercise program).

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

If treatment was directly paid or covered by another plan, Medically Necessary adjustments will be covered.

None of the following bariatric procedures are covered, individually or in combination:

- open vertical banded gastroplasty;
- laparoscopic vertical banded gastroplasty;
- open sleeve gastrectomy;
- open adjustable gastric banding.

Braces

A brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

Breast Reconstruction and Breast Prostheses

Coverage is provided for the following Services and Supplies following a mastectomy:

- surgical services for reconstruction of the breast on which the mastectomy was performed;
- surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
- post-operative breast prostheses; and
- mastectomy bras/camisoles and external prosthetics, that meet external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

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 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 www.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 Agreement on the same basis as any other medical benefit. Please refer the "Definitions" section of this Agreement for a complete description of the services.

Clinical Trials

Benefits are payable for routine patient services associated with an approved clinical trial (Phases I-IV) for treatment of cancer or other life-threatening diseases or conditions for a covered person who meets the following requirements::

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

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

An approved clinical trial must meet one of the following requirements:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be approved for cancer clinical trials by an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services;
- be conducted under an investigational new drug application reviewed by the Food and Drug administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

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

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

Routine Patient Services do not include:

- the investigational item, device, or service itself;
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

- 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.

Rehabilitative Chiropractic Care Services

Diagnostic and treatment services utilized in an office setting by participating chiropractic Physicians and Osteopaths. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function. For these services you have direct access to qualified participating chiropractic Physicians; you do not need a Referral from your PCP.

The following limitations apply to Chiropractic Care Services:

- Services are not covered when they are considered custodial, training, educational or developmental in nature.
- Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living after an illness or injury.

The following are specifically excluded from chiropractic care services:

- Services of a Chiropractor which are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting;
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent reoccurrence or to maintain the patient's current status;
- Vitamin therapy;
- Massage therapy in the absence of other modalities.

Compression Garments

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

Cosmetic Surgery

Cosmetic Surgery is covered only for reconstructive surgery that constitutes Medically Necessary care and treatment of medically diagnosed services required for the prompt repair of accidental injury, treatment of congenital defects and birth abnormalities are covered for eligible Dependent children.

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

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

Non-life threatening complications of a non-covered cosmetic surgery are not covered. This includes, but is not limited to, subsequent surgery for reversal, revision or repair related to the procedure.

Dental Care/Confinement/Anesthesia

This Agreement provides benefits for dental care for a fractured jaw or an accidental Injury to sound natural teeth.

With respect to dental confinement/anesthesia, facility and anesthesia services for hospitalization in connection with dental or oral surgery will be covered, if the confinement has been authorized by Cigna because of a hazardous medical condition. Such conditions include heart problems, diabetes, hemophilia, dental extractions due to cancer related conditions, and the probability of allergic reaction (or any other condition that could increase the danger of anesthesia). All facility services must be provided by a Participating Physician.

Benefits are payable for general anesthesia/radiation therapy and associated facility charges for dental procedures rendered in a Participating Hospital or Freestanding Outpatient Surgical Facility for:

- a Member who is a child;
- a Member at any age who is developmentally disabled; or
- a Member whose health is compromised and general anesthesia is Medically Necessary.

Diabetic Service and Supplies

Coverage is provided for the following medically appropriate supplies, devices, and appliances prescribed by a Participating Physician for the treatment of diabetes, and diabetic supplies as stated in the definition section, including:

1) podiatric appliances for prevention of complications associated with diabetes; foot orthotic devices and inserts (therapeutic shoes: including Depth shoes or Custom Molded shoes.);
2) any other device, medication, equipment or supply for which coverage is required under Medicare guidelines pertaining to diabetes management; and
3) charges for training by a Participating Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
    a. Medically appropriate visits when diabetes is diagnosed;
    b. Visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
    c. Visits when reeducation or refresher training is prescribed by the Physician; and
    d. Medical nutrition therapy (education) related to diabetes management.

Custom-Molded shoes will only be covered when the Member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and *any* of the following complications involving the foot: peripheral neuropathy with evidence of callus formation;

a history of preulcerative calluses; history of previous ulceration; foot deformity; previous amputation of the foot or part of the foot; or poor circulation.

For purposes of this Covered Service:

Depth Shoes means the shoe has a full length, heel-to-toe filler that, when removed, provides a minimum of 3/16th inch of additional depth used to accommodate custom-molded or customized inserts; are made of leather or other suitable material of equal quality; have some sort of shoe closure; and are available in full and half sizes with a minimum of three widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent.

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

Durable Medical Equipment

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

This Agreement 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 or prescribed by a Physician;
- Serves a medical purpose and is expected to be 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 requirements in order to be eligible for benefits under this Agreement. 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 most cost-effective 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 has previously been determined by Cigna to fall into a continuous rental category and requires frequent maintenance and servicing.

Coverage for repair, replacement or duplicate equipment is provided only when approved as Medically Necessary. All maintenance and repairs that result from a Member's misuse are the Member's responsibility.

Eosinophilic Gastrointestinal Disorder

Coverage is provided for amino acid-based formula that is ordered by a Participating Physician or registered nurse practitioner if:

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

Family Planning Infertility

Diagnostic services rendered for infertility evaluation are covered. Any medical treatment and/or prescription related to infertility once diagnosed are excluded by the Agreement.

Family Planning Service

Family planning services including: medical history; physical examination; related laboratory tests; medical supervision in accordance with generally accepted medical practice; other Medical Services; information and counseling on contraception; implanted/injected contraceptives; and after appropriate counseling, Medical Services connected with surgical therapies (vasectomy or tubal ligation).

Foreign Country Providers Services

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

Benefits are subject to all terms, conditions, limitations, penalties, and exclusions of this Agreement and will not be more than would be paid if the service or supply had been received in the United States.

Genetic Testing

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

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

Genetic counseling is covered if covered genetic testing is planned or if a Member is at risk for an inherited disease or carrier state.

Habilitative Services

Coverage is provided for services designed to assist You to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame are payable as stated in the Benefit Schedule.

Coverage is provided for Covered Expenses for the necessary care and treatment of loss or impairment of speech, as stated in the Benefit Schedule.

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.

The term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided. Limits on the number of visits provided under the Rehabilitative benefit do NOT apply to Habilitative Services.

Special Note:
Additional visits for Habilitative Services beyond any maximum number of visits stated 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. Any such additional visits must be authorized by Cigna in advance of treatment being provided.

Hearing Aids

Coverage is provided for an annual hearing exam and hearing aid devices to the limit shown in the benefit schedule. Coverage is also provided for the following services:

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

Home Health Services

Coverage is provided for home health services if:

- the Physician overseeing the Member's treatment has determined a medical need for home health care and developed a plan of care that is reviewed at thirty day intervals by the Physician;
- the care described in the plan of care must be for intermittent skilled nursing, therapy, or speech services;
- the Member is homebound unless services are determined to be Medically Necessary by the Cigna Medical Director;
- the home health agency delivering care is certified by the state in which the care is received; and
- the care that is being provided is not Custodial Care

Coverage does not include non-skilled care and/or Custodial Services (e.g. bathing, eating, toileting).

Home health services are those skilled health care services that can be provided during visits by Other Participating Health Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Participating Health Professionals. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations.

A “visit” is defined as a period of 4 hours or less. Necessary consumable medical supplies and home infusion therapy administered or used by other participating health care professionals in providing home health services are covered. Physical, occupational, and other Rehabilitative Therapy services provided in the home are subject to the benefit limitations described under "Rehabilitative Therapy" in the Benefit Schedule.

Hospice Care

This Agreement provides benefits for Covered Expenses for hospice care including palliative and supportive medical, nursing and other health services through home or inpatient care during the Illness; a program for Members 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 Plan is sold.

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

The Physician must consent to the Hospice Care Program, and must be consulted in the development of the treatment plan.

Imaging Benefits

Outpatient and ambulatory magnetic resonance imaging (MRI/MRA), PET Scans, ECT and BEAM (Brain Electrical Activity Mapping), CAT/CT imagery.

Infertility

Coverage for Infertility is limited to services to diagnose the underlying cause of the infertility condition; treatment of the infertility condition is not covered. Diagnostic services rendered for infertility evaluation are covered. Any medical treatment and/or prescription related to infertility once diagnosed are excluded by the Agreement.

Internal Prosthetic/Medical Appliances

Coverage for Medically Necessary Prosthetic/Medical Appliances authorized by the Primary Care Physician consists of permanent or temporary internal aids and supports for non-functioning body parts, and for internal and external breast prosthesis following a mastectomy, and testicular implants following a Medically Necessary removal of the testicals. Medically Necessary repair, maintenance or replacement of a covered appliance is covered.

Laboratory and Diagnostic and Therapeutic Radiology Services

Laboratory services and radiation therapy and other diagnostic and therapeutic radiological procedures.

Mastectomy and Related Procedures

This Agreement provides benefits for Covered Expenses for hospital and professional services 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 Member was covered under this Agreement. 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 Member elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

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

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

Maternity Care Services

Your HMO Agreement provides pregnancy and post-delivery care benefits for You and Your Family Members.

All comprehensive benefits described in this Agreement are available for maternity services. Comprehensive Hospital benefits for routine nursery care of a newborn child are available so long as the child qualifies as an Eligible Dependent as defined in the section of this Agreement titled “Eligibility”. This includes Covered Expenses for Covered Services under this Agreement for a newborn child when the child is adopted by the Subscriber within the child’s first year of life, or when the Subscriber is legally obligated to pay the cost of charges for the child’s birth in excess of the birth mother’s coverage.

The mother and her newborn child are entitled, under federal law, to inpatient Hospital coverage for a period of 48 hours following an uncomplicated vaginal delivery; and 96 hours following an uncomplicated delivery by cesarean section. 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 Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. If a decision is made between a mother and doctor to discharge a mother or newborn child from inpatient care before the 48 or 96 hour time period, coverage for timely post-delivery care is available.

This Agreement provides benefits for complications of pregnancy. Benefits are available for other pregnancy and maternity care as indicated above under “Maternity Care Services”.

We will provide coverage for the costs of the birth of any child legally adopted by the insured, subject to all limitations that would apply to any maternity claim under the Policy, if: (a) the child is adopted within one year of birth; (b) the insured is legally obligated to pay the costs of the birth; (c) all applicable deductibles and copayments for the services at issue have been paid by the insured; and (d) the insured has notified Us of his/her acceptability to adopt pursuant to Arizona R.S. § 8-105 within sixty days after such approval or within sixty days after a change in insurance policies, plans, or companies.

Medical Foods/Metabolic Supplements/Gastric Disorder Formula

Medical foods, metabolic supplements and gastric disorder formula to treat inherited metabolic disorders or a permanent disease/non-functioning condition in which an Insured Person is unable to sustain weight and strength commensurate with the Insured Person's overall health status are covered.

Metabolic disorders triggering medical food coverage are: (a) part of the newborn screening program as prescribed by Arizona statute; (b) involve amino acid, carbohydrate or fat metabolism; (c) have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and (d) require specifically processed or treated medical foods that are generally available only under the supervision and direction of a physician or a registered nurse practitioner, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

We will cover the cost of medical foods prescribed to treat inherited metabolic disorders covered under this contract, subject to any applicable copayments, deductibles or coinsurance.

For the purpose of this section, the following definitions apply:

1. "Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program as prescribed by Arizona statute.
2. "Medical Foods" means modified low protein foods and metabolic formula.
3. "Metabolic Formula" mean foods that are all of the following: (a) formulated to be consumed or administered enterally under the supervision of a medical doctor, registered nurse practitioner or doctor of osteopathy; (b) processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (d) essential to a person's optimal growth, health and metabolic homeostasis.
4. "Modified Low Protein Foods" means foods that are all of the following: (a) formulated to be consumed or administered enternally under the supervision of a medical doctor, nurse practitioner or doctor of osteopathy; (b) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; (d) essential to a person's optimal growth, health and metabolic homeostasis.

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

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

The following are not considered medically appropriate and are not covered as a Metabolic Food/Metabolic Supplement and Gastric Disorder Formula:

- Standard oral infant formula;
- Food thickeners, baby food, or other regular grocery products;
- Nutrition for a diagnosis of anorexia; and
- Nutrition for nausea associated with mood disorder, and end-stage disease.

Medical Supplies

Medical supplies include medically appropriate supplies which may be considered disposable, however, are required for a Member in a course of treatment for a specific medical condition. Supplies must be obtained from a Participating Physician. Over the counter supplies, such as band-aids and gauze are not covered.

Mental Health and Substance Use Disorder Services

Inpatient Mental Health Services

Services that are provided by a Participating Hospital for the treatment and evaluation of mental health during an inpatient admission.

Outpatient Mental Health Services

Services of Participating Providers who are qualified to treat mental health when treatment is provided on an outpatient basis in an individual, group or structured group therapy program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interferes with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention), outpatient testing and assessment including neuropsychological testing, and medication management when provided in conjunction with a consultation.

Outpatient Substance Use Disorder Rehabilitation Services

Services for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual, group, structured group or intensive outpatient structured therapy program.

Intensive outpatient structured therapy programs consist of distinct levels or phases of treatment that are provided by a certified/licensed substance use disorder program. Intensive outpatient structured therapy programs provide nine or more hours of individual, family and/or group therapy in a week.

Substance Use Disorder Residential Treatment Services

Services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute substance use disorder conditions. This includes voluntary and court-ordered treatment.

Substance Use Disorder Residential Treatment Center means an institution which:

a. specializes in the treatment of psychological and social disturbances that are the result of substance use disorder;

b. provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians;

c. provides twenty-four (24) hour care, in which a person lives in an open setting; and

d. is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Use Disorder Residential Treatment Center when he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Inpatient Substance Use Disorder Services

Services that are provided by a Participating Hospital for the treatment and evaluation of substance use disorder during an inpatient admission.

Substance Use Disorder Detoxification Services

Detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs, and medication management when provided in conjunction with a consultation. The Cigna Medical Director will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Excluded Mental Health and Substance Use Disorder Services

The following mental health and substance use disorder services are specifically excluded from coverage under this Agreement:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this Agreement;
- Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Treatment of chronic conditions not subject to favorable modification according to generally accepted standards of medical practice;
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.

- Vocational or religious counseling.
- I.Q. testing.
- Residential treatment (unless associated with chemical or alcohol dependency as described in the Residential Substance Use Disorder Residential Treatment provisions);
- Complementary and alternative medicine services, including but not limited to: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; music therapy; meditation; visualization; acupuncture; acupressure, reflexology, light therapy, aromatherapy, energy-balancing; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf.
- marriage counseling;
- Custodial Care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline; and
- Biofeedback is not covered for reasons other than pain management.

Nutritional Evaluation

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

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

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

Obstetrical and Gynecological Services

Obstetrical and gynecological services that are provided by qualified Participating Physicians for pregnancy, well-women gynecological exams, primary and preventive gynecological care and acute gynecological conditions. For these Services you have direct access to qualified Participating Physicians; you do not need a Referral from your Primary Care Physician.

Orthognathic Surgery

Orthgonothic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) are covered if approved as Medically Necessary.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  a. Rigid and semi-rigid custom fabricated orthoses;
  b. Semi-rigid pre-fabricated and flexible orthoses; and
  c. Rigid pre-fabricated orthoses, including preparation, fitting and basic additions, such as bars and joints.

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

- Custom foot orthotics – custom foot orthoses are only covered as follows:
  a. For Members with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  b. When the foot orthosis is an integral part of a leg brace, and it is necessary for the proper functioning of the brace;
  c. When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of illness, injury, or congenital defect; and
  d. For Members with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot, and there is reasonable expectation of improvement.

The following orthoses & orthotic devices are specifically excluded from coverage under this Plan, unless provided in the Diabetic Services and Supplies Section:

- Prefabricated foot orthoses;
- Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- Orthoses primarily used for cosmetic rather than functional reasons; and
- Orthoses primarily for improved athletic performance or sports participation.

Ostomy Supplies

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

Oxygen

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

Pediatric Dental Care

Pediatric dental care for Members less than 19 years of age are provided in the Pediatric Dental Care Policy in which the Member is enrolled. Pediatric Dental Care Policy benefits are subject to all the terms and conditions of the Pediatric Dental Care Policy.

Preventive Care Services Periodic Health Examinations

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

- Routine physical exams.
- Well Child exams, immunizations and an vision screening during an annual physical, performed by a Primary Care Physician,
- Annual mammogram, Pap test and Prostate Specific Antigen screening (PSA) and Digital Rectal Examination (DRE).
- Items or services that have an A or B rating in current recommendations of the U. S. Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

- For women, including pregnant women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including but not limited to:
    - Well woman visits to obtain recommended preventive services;
    - BRCA counseling about genetic testing and breast cancer chemoprevention counseling for women at higher risk;
    - Gonorrhea screening for all women at higher risk;
    - Chlamydia infection screening for younger women and women at higher risk;
    - Cervical cancer screening, HIV screening and counseling and sexually transmitted infections (STI) counseling for sexually active women;
    - HIV prevention education and risk assessment in women at least annually throughout their lifespan;
    - Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older;
    - Osteoporosis screening for women over age 60, depending on risk factors;
    - Domestic and interpersonal violence screening and counseling for all women;
    - Alcohol misuse screening and counseling;
    - Tobacco use screening and cessation interventions for tobacco users, and expanded counseling for pregnant tobacco users;
    - Contraception: FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
    - Folic acid supplements for women who may become pregnant;
    - Low-dose aspirin (81 mg/day) after 12 weeks of gestation for women who are at high risk for preeclampsia;
    - Hepatitis B screening for pregnant women at their first prenatal visit;
    - Syphilis screening for all pregnant women or other women at increased risk;
    - Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
    - Anemia screening on a routine basis for pregnant women;
    - Bacteriuria urinary tract screening or other infection screening for pregnant women;
    - Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
    - Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, including coverage of the rental of one breast pump per birth up to the purchase price as ordered or prescribed by a Physician for pregnant and nursing women.
- Counseling for alcohol misuse, breastfeeding/lactation, depression/psychological, genetic, healthy diet/ nutrition, obesity in adults and children, preventative medication, sexually transmitted infections, domestic violence, skin cancer behavioral and tobacco use.

- An adult vision screening during an annual physical, performed by a Primary Care Physician

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.

Prosthetics and Orthotics

External Prosthetic Appliances and Devices

This Agreement provides benefits for Covered Expenses made or ordered by a Physician for the initial purchase and fitting of External Prosthetic Appliances and Devices available only by prescription which are Medically Necessary for the alleviation or correction of Illness, Injury, or congenital defect.

External Prosthetic Appliances and Devices include Prostheses/Prosthetic Appliances and Devices, Orthoses and Orthotic Devices; Braces; Splints, and Wigs and hair pieces are covered verifying diagnosis of alopecia as a result of chemotherapy, radiation therapy, second or third degree burns.

Coverage for External Prosthetic Appliances and Devices is limited to the most appropriate and cost effective alternative. This includes coverage for repair, maintenance or replacement of a covered Prosthetic Appliance or Device, unless replacement is required because of misuse or loss of the Prosthetic on the part of the Member.

Coverage is provided for custom foot Orthoses and other Orthoses as follows:

- Only the following non-foot Orthoses are covered, when Medically Necessary:
  a. Rigid and semi-rigid custom fabricated Orthoses;
  b. Semi-rigid pre-fabricated and flexible Orthoses; and
  c. Rigid pre-fabricated Orthoses, including preparation, fitting and basic additions, such as bars and joints.
- Custom foot Orthotics are only covered when medically necessary, as follows:
  a. For Members with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  b. When the foot Orthosis is an integral part of a leg brace, and it is necessary for the proper functioning of the brace;
  c. When the foot Orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of illness, injury, or congenital defect; and
  d. For Members with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot, and there is reasonable expectation of improvement.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the Member will not be covered; and

- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Frequency of replacement is limited as follows:

- No more than once every 24 months for Members 19 years of age and older;
- No more than once every 12 months for Members 18 years of age and under; and
- Replacement due to a surgical alteration or revision of the site.

The following External Prosthetic Appliances and Devices are specifically **excluded** from coverage under this Agreement:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.
- Electronic prosthetic limbs or appliances are not covered unless Medically Necessary, when a less-costly alternative is not sufficient.

The following Orthoses & Orthotic Devices are specifically **excluded** from coverage under this Agreement, except as provided in the Diabetic Services and Supplies benefit:

- Prefabricated foot Orthoses;
- Cranial banding/cranial orthoses/other similar devices, except when used postoperatively for synostotic plagiocephaly.
- Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- Orthoses primarily used for cosmetic rather than functional reasons; and
- Non-foot Orthoses, except **only** the following non-foot orthoses are covered when Medically Necessary:
    a. Rigid and semi-rigid custom fabricated Orthoses;
    b. Semi-rigid pre-fabricated and flexible Orthoses; and
    c. Rigid pre-fabricated Orthoses, including preparation, fitting and basic additions, such as bars and joints.

Reconstructive Surgery

Coverage is provided for Medically Necessary reconstructive surgery or therapy for medically diagnosed congenital defects and birth abnormalities for newborns, adopted children and children placed for adoption. Additionally, reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement due to accidental injury or congenital abnormality, which is accompanied by functional deficit (other than abnormalities of the jaw or related to TMJ disorder) provided that:

- the surgery or therapy restores or improves function or decreases risk of functional impairment; or
- reconstruction is required as a result of Medically Necessary, non-cosmetic surgery.

Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the Cigna Medical Director.

Self-Management Training

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

1. Morbid obesity
2. Diabetes
3. Cardiovascular disease
4. Hypertension
5. Kidney disease
6. Eating disorders
7. Gastrointestinal disorders
8. Food allergies
9. Hyperlipidemia

Services for Pulmonary and Cardiac Rehabilitation

This Agreement provides benefits for Covered Expenses incurred for pulmonary rehabilitation, and for cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Cardiac rehabilitation must be Physician directed with EKG monitoring.

Services for Rehabilitative Therapy (Physical Therapy, Occupational Therapy, Speech Therapy, and Cardiac & Pulmonary Rehabilitation)

The term "visit" includes any outpatient visit to a Physician or Facility during which one or more Covered Services are provided.

Benefits for the therapeutic use of heat, cold, exercise, electricity, ultraviolet light, or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury; and the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function are payable up to the maximum number of visits as stated in the Benefit Schedule.

Benefits for Covered Expenses will be provided for the necessary care and treatment of loss or impairment of speech, payable up to the number of visits as stated in the Benefit Schedule.

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.

To be covered, all therapy services must be restorative in nature. Restorative therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of injury or sickness. Restorative therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the injury or illness. Services are not covered when they are considered custodial, training, educational or developmental in nature.

Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living after an illness or injury. Note: this provision does not apply to services for Habilitative Therapy.

Special Note:
Additional visits for Physical and Occupational Therapy 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 Member's impairment; and
- Cigna authorizes this in advance.

The following services are specifically excluded from coverage under the Rehabilitative Services benefit:

- Services of a Provider which are not within his or her scope of practice, as defined by state law;
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent reoccurrence or to maintain the patient's current status;
- Vitamin therapy;
- Massage therapy in the absence of other modalities.

Smoking Cessation

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

Splints

A splint is defined as an appliance for preventing movement of joints or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the Member will not be covered; and
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Coverage for replacement is limited as follows:

- No more than once every 24 months for Members 19 years of age and older;
- No more than once every 12 months for Members 18 years of age and under; and
- Replacement due to a surgical alteration or revision of the site.

The following external prosthetic appliances and devices are specifically excluded from coverage under this Agreement:

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

Treatment for Temporomandibular Joint Disorder/Dysfunction

Medical services for temporomandibular joint disorder or dysfunction (TMJ/TMD), which is the result of:

- an accident;
- trauma;
- a congenital defect;
- a developmental defect; or
- pathology;

are covered on the same basis as any other medical condition.

Covered expenses include diagnosis and treatment of TMJ/TMD that is recognized by the medical or dental profession as effective and appropriate treatment for TMJ/TMD, including intra-oral splints that stabilize the jaw joint.

Organ and Tissue Transplants and Related Specialty Care

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. This coverage is subject to the following conditions and limitations.

Coverage is provided for both the recipient and donor of a covered transplant under the recipient's plan.

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: including but not limited to: 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.
- Cornea transplants are not covered by the LifeSOURCE Provider contracts, but are covered when received from a Participating Provider facility.
- 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 deceased 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.

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: Most 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 not be covered. For more information on whether an In-Network facility is contracted with Cigna to provide transplant services, contact Your Cigna case manager or call 1-800-287-0539.

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. Coverage is also provided for taxable expenses incurred for meals and food purchased in connection with a pre-approved organ/tissue transplant, subject to the following conditions and limitations. Benefits for transportation, lodging, food and meals are available to You only if You are the recipient of a pre-approved organ/tissue transplant from a designated Cigna LifeSOURCE Transplant Network® facility. The term “recipient” includes an Insured Person receiving authorized transplant-related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the Member receiving the transplant will include Charges for:

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

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

Travel expenses that are NOT covered include, but are not limited to the following:

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

Note: Transplant travel benefits are not available for cornea transplants.

Transplant Travel Services are only available when the Member 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 Member is a donor.

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

Other Services Available through LifeSOURCE Facilities

The following services are covered but ONLY when provided at a Cigna LifeSOURCE Transplant Network facility. The services are not covered when provided by any other Provider, including any other Cigna Participating Provider:

- **Ventricular Assist Device**
  Ventricular Assist Device (VAD) implantation procedures are covered only when performed at a Cigna LifeSOURCE Transplant Network® facility with an approved heart transplant program. VAD implantation procedures received at any other Providers are not covered.
- **Advanced Cellular Therapy**
  Advanced cellular therapy, including but not limited to, immune effector cell therapies and Chimeric Antigen Receptor Therapy (CAR-T) cellular therapy, is covered only when performed at a Cigna LifeSOURCE Transplant Network® facility with an approved stem cell transplant program. Advanced cellular therapy received at other facilities is not covered.

PRESCRIPTION DRUG BENEFITS

The Prescription Drug benefits shown below are subject to all of the terms, conditions and limitations contained in this Agreement.

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

Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the Deductible shown in the Benefit Schedule and, once the Deductible is satisfied, subject to any applicable Copayment or Coinsurance shown in the Benefit Schedule. For additional information on the Deductible, please refer to the Definitions section of the Agreement.

Cigna's Prescription Drug List is available upon request by calling the Member Services number on Your ID card and at http://www.cigna.com/ifp-drug-list.

Member Payments

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 Summary. Drugs on the Narrow Therapeutic Index (NTI) are excluded.

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

- the Copayment 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 Agreement, **Cigna will not** allow the dollar amount of the coupon, or offer to reduce Your Deductible, Copayment 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 Agreement.

Prescription Drug List Management

The Prescription Drug List, which may also be referred to as a formulary, is a list of Prescription Drugs or Related Supplies that the Policy covers. The Prescription Drug List is organized by coverage "tiers" that are subject to different levels of cost-share requirements. The Policy's coverage tiers may contain Prescription Drugs or Related Supplies that are Generic Drugs, Brand Drugs, or Specialty Medications.

The Prescription Drug List is managed by the Business Decision Team, which makes, subject to the P&T Committee's review and approval of the Prescription Drug List, coverage tier placement decisions of Prescription Drugs or Related Supplies and/or applies utilization management requirements to certain Prescription Drugs or Related Supplies. Your Policy's coverage tiers may contain Prescription Drugs or Related Supplies that are Generic Drugs, Brand Drugs or Specialty Medications. Placement of any Prescription Drug or Related Supplies in a specific tier, and application of utilization management requirements to a Prescription Drug, depends on a number of clinical and

economic factors. Clinical factors include, without limitation, the P&T Committee's evaluations of the place in therapy, or relative safety or relative efficacy of the Prescription Drug or Related Supplies, and economic factors include, without limitation, the cost and/or available rebates for Prescription Drugs or Related Supplies. Whether a particular Prescription Drug or Related Supplies is appropriate for You or any of Your Dependents, regardless of its eligibility coverage under Your Policy, is a determination that is made by You (or Your Dependent) and the prescribing Physician.

The Prescription Drug List is reviewed at least annually. While most changes to the Prescription Drug List occur on the Policy Year anniversary date, the Prescription Drug List may change throughout the Policy Year. New Prescription Drug Products are reviewed by the P&T Committee and, based on consideration of the factors set forth previously, may be added to the Prescription Drug List during the Policy Year. The coverage status of a Prescription Drug or Related Supplies already included on the Prescription Drug List may change periodically during the Policy Year for various reasons. For example, a Prescription Drug or Related Supplies may be removed from the market, a new Prescription Drug in the same therapeutic class may become available, or the cost of a Prescription Drug or Related Supplies may increase.

As a result of coverage changes, You may, for example, be required to pay more or less for that Prescription Drug or Related Supplies, or try another covered Prescription Drug or Related Supplies. Please access www.mycigna.com through the Internet or call member services at the telephone number on Your ID card for the most up-to-date coverage tier status, utilization management, or other coverage limitations for a Prescription Drug or Related Supplies.

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

We will inform You, upon Your request, if a drug is included on the Prescription Drug List within 3 business days. To make a request, You can call Customer Service at the phone number on Your ID card or You can 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.

Prescription Drugs and Specialty Medication Covered as Medical

When Prescription Drugs and Specialty Medications covered by Cigna 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 Agreement. However, they may still be subject to Prescription Drug Prior Authorization or Step Therapy requirements.

For certain Limited Distribution Drugs covered under the medical benefits of this Agreement, the Provider who administers the drug must obtain the drug directly from a Cigna contracted Limited Distribution Drug Provider in order for that drug to be covered. If you have questions about the acquisition of the drugs being administered to You, please consult Your Provider.

Self-Administered Injectable and Non-Self-Administered Injectable Drugs and Specialty Medication Benefits

Drugs Covered under the Prescription Drug Benefits

Self-Administered Injectable Drugs, and syringes for the self-administration of those drugs, are covered under the Prescription Drug benefits of this Agreement. To determine if a drug prescribed for You is covered, You can:

- log into Your myCigna.com account and
- view the Cigna Prescription Drug List at http://www.cigna.com/ifp-drug-list, and
- then choose the Cigna Prescription Drug List for Your state.

Note: the drugs may be subject to Prescription Drug Prior Authorization or Step Therapy requirements.

Drugs Covered under the Medical Benefits

Non-Self-Injectable Drugs and Injectable Specialty Medications on Cigna's Prescription Drug List are covered under the medical benefits of this Agreement when:

Injectable Drugs and Injectable Specialty Medications on Cigna's Prescription Drug List are administered in a healthcare setting by a Physician or health care professional, and are billed with the office or facility charges.

You or Your Physician can view the Cigna Prescription Drug List by:

- accessing http://www.cigna.com/ifp-drug-list, and
- choose Your state.

Note: the drugs may be subject to Prescription Drug Prior Authorization or Step Therapy requirements.

Covered Expenses

If a Member, while covered under this Agreement, 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 a Member by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When a Member is 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.

Covered Prescription Drugs include, but are not limited to:

- Outpatient Drugs and medications that Federal and/or applicable State law restrict to sale by Prescription only, except for Insulin which does not require a prescription.
- 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; oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.

- Pharmaceuticals to aid smoking cessation in accordance with “A” or “B” recommendations of the U.S. Preventive Services Task Force.
- Orally administered anti-cancer medications prescribed in connection with cancer chemotherapy treatments.
- All non-infused compound Prescriptions that contain at least one FDA approved Prescription ingredient compounded from an FDA approved finished pharmaceutical product and are otherwise covered under the Prescription benefits, excluding any bulk powders included in the compound.
- Contraceptive drugs and devices approved by the FDA.
- Specialty Medications.

Covered Drugs or medicines 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 Member'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 a Members Illness.
- Purchased from a licensed retail Pharmacy or ordered by mail Cigna's Home Delivery Pharmacy Program.
- The Drug or medicine must not be used while the Member is an inpatient in any facility.
- The Prescription must not exceed the days’ supply indicated in the “Limitations” section below.
- Infusion and Injectable Specialty Prescription Medications may require Prior Authorization or precertification.

Prescription Drug Exclusions

The following are not covered under this Agreement. No payment will be made for the following expenses:

- Drugs not approved by the Food and Drug Administration.
- Drugs that are not on the Prescription Drug List and not otherwise approved for coverage through the non-Prescription Drug List exception process;
- Drugs, devices and/or supplies, available over the counter that do not require a prescription by federal or state law except as otherwise stated in this Policy, or specifically designated as No Cost Preventive Care and required by the Patient Protection and Affordable Care Act (PPACA);
- Drugs that do not require a Federal legend (a Federal designation for drugs requiring supervision of a Physician), other than insulin.
- Drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin.
- 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.

- Infertility related drugs, except those required by the Patient Protection and Affordable Care Act (PPACA
- 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;
- Drugs used for weight loss, weight management, metabolic syndrome; and antiobesity agents.
- Drugs that are Experimental or Investigational, except as specifically stated in the section of this Agreement titled “Clinical Trials”.
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals.
- Implantable contraceptive products are covered under the medical benefits of the Agreement.
- Prescription and non-prescription supplies (such as, ostomy supplies), devices, and appliances other than Related Supplies, except for those pertaining to Diabetic Supplies and Equipment.
- Prescription vitamins (other than pre-natal vitamins), dietary supplements, herbal supplements, and fluoride other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA).
- Drugs used for cosmetic purposes that have no medically acceptable use, such as, drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products.
- Injectable or infused Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions are covered under the medical benefits of this Agreement.
- Medications used for travel prophylaxis, except for anti-malarial drugs.
- Drugs obtained outside of the United States.
- Any fill or refill of Prescription Drugs and Related Supplies that is to replace those lost, stolen, spilled, spoiled or damaged before the next refill date.
- Drugs used to enhance athletic performance.
- Drugs which are to be taken by or administered to a Member while the Member is 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.
- Any 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 Member.

Prescription Drug Benefit Limitations

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

- Up to a 30-day supply, at a Participating Retail Pharmacy for drug tiers 1 through 4 and up to a 30-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers please refer to the Agreement Benefit Schedule): or
- Up to a 90- day supply, at a Participating 90- Day Retail Pharmacy for drug tiers 1 through 4 and up to a 30-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging. To locate a Participating 90- Day Retail Pharmacy you can call the Member Services number on Your ID card or go to www.cigna.com/ifp-providers. (for detailed information about drug tiers please refer to the Benefit Schedule)
- Up to a 90-day supply at a Cigna's Home Delivery Pharmacy for drug tiers 1 through 4 and up to a 30-day supply of tier 5 drugs unless limited by the drug manufacturer's packaging (for detailed information about drug tiers please refer to the Benefit Schedule).
- To a dosage and/or dispensing limit as determined by the P&T Committee.
- Infusion and Injectable Specialty Prescription Medications may require Prior Authorization.
- 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.

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. To obtain Prior Authorization, 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 a Member to follow certain steps before covering some Prescription Drugs and Related Supplies, including some higher-cost and Specialty Medications. 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.. 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 that is 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, Your 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 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 Agreement, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered. Please see the section of this Agreement entitled "WHEN YOU HAVE A COMPLAINT OR AN APPEAL" which describes the process for the External Independent Review.

If You have questions about specific Prescription Drug List exceptions, 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 its release onto the market, or a clinical justification must be documented if this timeframe is not met.

Reimbursement/Filing a Claim

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

To purchase Prescription Drugs or Related Supplies from a Cigna's Home Delivery Pharmacy Program, see the home delivery brochure on www.mycigna.com, or contact member services for assistance at the number on Your ID card

Claims and Customer Service

Drug claim forms are available upon written request to:

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

For home delivery Pharmacy claims:
Cigna Home Delivery Pharmacy
P.O. Box 1019
Horsham, PA19044-1019
1-800-835-3784

BENEFIT EXCLUSIONS AND LIMITATIONS

Any services which are not described as covered in the Benefit Schedule, Services and Benefits section, or in an attached rider, or are specifically excluded in the Services and Benefits section benefit language or an attached rider, are not covered under this Agreement.

Benefit Exclusions

In addition, the following are specifically excluded Services:

1. Care for health conditions which has not been provided by a Primary Care Physician, provided by Referral from a Primary Care Physician or authorized by a Primary Care Physician or the Cigna Medical Director, except for immediate treatment of a Medical Emergency/Emergency Medical Condition
2. Services received before the Effective Date of coverage.
3. Services received after coverage under this Agreement ends.
4. Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Physician, from any of the following
    a. Yourself or Your employer;
    b. A person who lives in the Member's home, or that person's employer;
    c. A facility or health care professional that provides remuneration to You, directly or indirectly, or to an organization from which you receive, directly or indirectly, remuneration.
5. Care for health conditions that are required by state or local law to be treated in a public facility.
6. Care required by state or federal law to be supplied by a public schools system or school district.
7. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
8. Treatment of an Illness or Injury which is due to war, declared or undeclared.
9. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
10. Services of a Hospital emergency room for any condition that is not an Emergency Medical Condition as defined in this Agreement.
11. Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
12. Any services and supplies for or in connection with Experimental, Investigational or Unproven services. Experimental, Investigational or Unproven services do not include routine patient care costs related to qualified clinical trials as described in your Agreement.
13. Cosmetic surgery, therapy or surgical procedures primarily for the purpose of altering 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 of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological

symptomatology or psychosocial complaints related to one's appearance. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, the eyelids, face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of portion of the body, including, the breast, face, lips, jaw, chin, nose, ears or genital; hair transplantation; chemical face peels or abrasion of the skin; electrolysis diplation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function, or surgery, which is Medically Necessary.

14. The following services are excluded from coverage regardless of clinical indications;
    a. Macromastia or Gynecomastia Surgeries;
    b. Surgical treatment of varicose veins;
    c. Abdominoplasty;
    d. Panniculectomy;
    e. Rhinoplasty;
    f. Blepharoplasty;
    g. Redundant skin surgery;
    h. Removal of skin tags;
    i. Acupressure;
    j. Craniosacral/cranial therapy;
    k. Dance therapy, movement therapy;
    l. Applied kinesiology;
    m. Rolfing;
    n. Prolotherapy; and
    o. Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
15. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, Charges made for services or supplies provided for or in connection with a fractured jaw, or an accidental injury to sound natural teeth are covered. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch, except for pediatric dental services.
16. Any medical and surgical services for the treatment or control of obesity that are not included under the "Services and Benefits" section of this Agreement
17. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
18. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Services and Benefits."

19. All services related to infertility once diagnosed, including but not limited to, infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
20. Reversal of male and female voluntary sterilization procedures.
21. 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.
22. Any treatment, prescription drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire
23. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
24. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
25. Non-medical counseling or ancillary services including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, or mental retardation, except as specifically stated in this Agreement.
26. 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 which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected, except as specifically stated in this Agreement.
27. 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; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnotism; 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.
28. 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.
29. 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.

30. Educational services except for Diabetes Self-Management Training; treatment for autism; counseling/ educational services for breastfeeding; physician counseling regarding alcohol misuse, preventive medication, obesity, nutrition, tobacco cessation and depression; preventive counseling and educational services specifically required under Patient Protection and Affordable Care Act (PPACA) or and as specifically provided or arranged by Cigna.
31. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services", "Outpatient Facility Services", "Home Health Services", Diabetic Services", or "Breast Reconstruction and Breast Prostheses" sections of the "Services and Benefits" section. Unless covered in connection with the services described in the "Inpatient Services at Other Participating Health Care Facilities" or "Home Health Services" provisions, Durable Medical Equipment items that are not covered, include but are not limited to those listed below:
    a. Hygienic or self-help items or equipment;
    b. Items or equipment primarily used for comfort or convenience such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;
    c. Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
    d. Institutional equipment, such as air fluidized beds and diathermy machines;
    e. Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, braces and splints;
    f. Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
    g. Items which under normal use would constitute a fixture to real property, such as lifts, ramps, railings, and grab bars; and
    h. Hearing aid batteries (except those for cochlear implants) and chargers.
32. Private hospital rooms and/or private duty nursing except as provided in the "Home Health Services" or "Hospice Services" section of "Services and Benefits." , or when deemed medically appropriate by Us. Private duty nursing will not be excluded in an inpatient setting, if skilled nursing is not available.
33. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
34. Orthopedic shoes (except when joined to braces), shoe inserts, foot orthotic devices except as required by law for diabetic patients.
35. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, orthotics, elastic stockings, garter belts, corsets, dentures and wigs, except as provided in "Services and Benefits" section of the Agreement.
36. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.

37. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery and pediatric vision).
38. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy, except for pediatric vision.
39. Treatment by acupuncture.
40. All non-prescription Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription; Injectable drugs ("Self-administered Injectable" drugs) that do not require Physician supervision; All non-injectable Prescription Drugs, Injectable Drugs that do not require Physician supervision and are typically considered Self-administered Injectable Drugs, non-prescription drugs, and investigational and experimental drugs, and Self-administered injectable Drugs, except as stated in the Benefit Schedule and in the Prescription Drug section of this Service Agreement.
41. 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 Member's condition. Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
42. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
43. Membership costs or fees associated with health clubs and weight loss programs.
44. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
45. Dental implants for any condition.
46. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Cigna Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
47. Blood administration for the purpose of general improvement in physical condition.
48. Cost of biologicals that are immunizations or medications for purposes of travel, except anti-malarial drugs, or to protect against occupational hazards and risks unless Medically Necessary or indicated.
49. Cosmetics, dietary supplements and health and beauty aids.
50. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
51. All vitamins and medications and contraceptives available without a prescription ("over-the-counter") except for those covered under mandate of the 2010 Patient Protection and Affordable Care Act (PPACA).
52. Expenses incurred for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.

53. Massage therapy.
54. Complementary and alternative medicine services, including but not limited to: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; music therapy; meditation; visualization; acupuncture; acupressure, reflexology, light therapy, aromatherapy, energy-balancing; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf.
55. Any services provided by or at a place for the aged, a nursing home, or any facility a significant portion of the activities of which include rest, recreation, leisure, or any other services that do not consist exclusively of Covered Services.
56. In addition to the provisions of this "Exclusions and Limitations" section, You are subject to the conditions set forth in the “Other Sources of Payment for Services and Supplies."
57. The following mental health and substance use disorder services are specifically excluded from coverage under this Agreement:
    a. Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this Agreement;
    b. Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
    c. Treatment of chronic conditions not subject to favorable modification according to generally accepted standards of medical practice;
    d. Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
    e. Counseling for activities of an educational nature.
    f. Counseling for borderline intellectual functioning.
    g. Counseling for occupational problems.
    h. Counseling related to consciousness raising.
    i. Vocational or religious counseling.
    j. I.Q. testing.
    k. Residential treatment (unless associated with chemical or alcohol dependency as described in the Residential Substance Use Disorder Residential Treatment provisions);
    l. Complementary and alternative medicine services, including but not limited to: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; music therapy; meditation; visualization; acupuncture; acupressure, reflexology, light therapy, aromatherapy, energy-balancing; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf.
    m. marriage counseling;
    n. Custodial Care, including but not limited to geriatric day care.
    o. Psychological testing on children requested by or for a school system

p. Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline; and

q. Biofeedback is not covered for reasons other than pain management.

In addition to the provisions of this "Exclusions and Limitations" section, You will be responsible for payments on a fee-for-service basis for Service and Supplies under the conditions described in the "Reimbursement" provision of “Other Sources of Payment for Services and Supplies."

Benefit Limitations

Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision require prior authorization. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin

Circumstance Beyond the Cigna HMO Agreement’s Control. To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within Our control results in Our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Agreement, We will make a good faith effort to provide or arrange for the provision of the service or supplies, taking into account the impact of the event.

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

Start with Customer Service

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

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you can start the appeals procedure. We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems. The Appeals Process Information Packet ("Appeal Packet") describes the process by which Members may obtain information and submit concerns regarding service, benefits, and coverage. For more information, see the Appeals Process Information Packet ("Appeal Packet").
We will provide you a copy of the Appeal Packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating Provider at any time upon request. Just call Customer Services at the toll-free number that appears on your Benefit Identification card.

RELATION OF THE AGREEMENT TO OTHER SOURCES OF PAYMENT FOR HEALTH SERVICES

COORDINATION OF BENEFITS

This section describes what this Agreement 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/non-group 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 a 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.

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. 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.

Workers' Compensation

Benefits under this Agreement should not duplicate any benefit which the Member is entitled to receive under workers' compensation law. In the event Cigna renders or pays for health services which are covered by a workers' compensation plan, Cigna shall have a right to receive reimbursement either (1) directly from the entity which provides Member's workers' compensation coverage; or (2) directly from the Member to the extent, if any, that the Member has received payment from such entity, as follows:

1. Where Cigna has directly rendered or arranged for the rendering of services, Cigna shall have the right to reimbursement to the extent of the Prevailing Rates for the care and treatment so rendered.
2. Where Cigna does not render services but pays for those services which are within the scope of the "Services and Benefits" Section of the Agreement, Cigna shall have a right of reimbursement to the extent that Cigna has made payments for the care and treatment so rendered.

In addition, it is the Member's obligation to fully cooperate with any attempts by Cigna to recover such expenses against the Member's employer in the event that coverage is not available as a result of the failure of the employer to take the steps required by law or regulation in connection with such coverage.

Recovery of Excess Benefits

In the event a service or benefit is provided by Cigna which is not required by this Agreement, that service or benefit shall be considered an excess benefit. The payment or provision of an excess benefit may occur due to a claim overpayment or the provision of services to non-Members. Cigna shall have the right to recover to the extent of the excess benefit. If the excess benefit is a service, recovery shall be based upon the Reasonable Cash Value for that service. If the excess benefit is a payment, recovery shall be based upon the actual payment made. Recovery may be sought from any person or entity to, or for, or with respect to whom, such services were provided or such payments were made. This right of recovery shall be Cigna's alone and at its sole discretion. If determined necessary by Cigna, the Member (or his or her legal representative if a minor or legally incompetent), upon request, shall execute and deliver to Cigna such instruments and papers required and do whatever else is necessary to secure Cigna's rights hereunder.

Medicare Eligibles

If an Insured Person is eligible for Medicare, Cigna will calculate the claim payment for Covered Services according to the benefit levels of this Policy based on the allowed amount defined below, and pay this amount minus any amount paid by Medicare. Cigna will estimate the amount Medicare would have paid and reduce benefits by this amount for any Insured Person who is eligible to enroll in Medicare but is not enrolled. In no event will the amount paid exceed the amount that Cigna would have paid if it were the sole insurance carrier.

Under this scenario, the allowed amount will be the lesser of:

- The amount Medicare allowed or
- Cigna's Negotiated Rate for a Participating Provider or
- Cigna's Maximum Reimbursable Charge for a Non Participating Provider

Right to Receive and Release Information

We, without consent of or notice to You, may release to or obtain from any person or organization or governmental entity any information with respect to the administration of this Section. You shall provide Cigna any information it requests to implement this provision. We, without consent of or notice to You, may obtain information from and release information to any plan with respect to You in order to coordinate Your benefits pursuant to this section. You shall provide us with any information we request in order to coordinate Your benefits pursuant to this section.

Healthcare Physician Liens

Arizona law (A.R.S. §20-1072) prohibits Participating Physicians from charging You more than the applicable Copayment or other amount You are obligated to pay under this Service Agreement for Covered Services. However, Arizona law (A.R.S. §33-931, et seq.), also entitles certain Participating Physicians to assert a lien for their customary Charges for the care and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. This means that if You are injured and have a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, a Participating Physician may be entitled to a lien against available proceeds from any such insurer or payor in an amount equal to the difference between: (1) the applicable Member Copayment plus what the Participating Physician has received from Cigna as payment for Covered Services, and (2) the Participating Physician's full billed Charges.

AMENDMENT OR MODIFICATION OF AGREEMENT

Amendment or Modification by Consent of the Parties

The Agreement may be amended or modified at any time by Cigna with prior notification as indicated below. Cigna Amendments are effective as of the date indicated in the Amendment.

Amendment or Modification by Law or Regulation

The provisions of the Agreement are subject to the approval of all regulatory bodies and in the event that regulatory bodies request any amendment or modification of the Agreement, such amendment or modification shall supersede the provisions of the Agreement. Furthermore, any state or federal laws or regulations enacted or promulgated which are in conflict with the provisions of the Agreement shall be deemed modifications of the Agreement on the date such enactment or promulgation is applicable to this Agreement.

Amendment or Modification by Notice From Cigna

Cigna may amend or modify the provisions of this Agreement, including any Premium s and Copayments, by giving at least sixty (60) days prior written notice to the Subscriber.

Uniform Modification of Coverage

The provisions of this Agreement may be modified to reflect product revisions which have uniformly been made to this Individual and Family plan Agreement. Cigna reserves the right to modify this Agreement, including Agreement 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 Agreement form. We will only modify this Agreement for all Members in the same class and covered under the same Agreement form, and not just on an individual basis.

Cigna 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.

Amendment or Modification by Law or Regulation

The provisions of the Agreement are subject to the approval of all regulatory bodies and in the event that regulatory bodies request any amendment or modification of the Agreement, such amendment or modification shall supersede the provisions of the Agreement. Furthermore, any state or federal laws or regulations enacted or promulgated which are in conflict with the provisions of the Agreement shall be deemed modifications of the Agreement on the date such enactment or promulgation is applicable to this Agreement.

Modification in the Event of Invalidation of the Patient Protection and Affordable Care Act

Cigna reserves the rights to (i) change the rates chargeable under the policy and (ii) amend the terms of the Agreement to eliminate, alter, or modify provisions required only by the Patient Protection and Affordable Care Act (P.L. 111-148) in the event of either (a) entry of a final judgment by a court declaring all or part of the law invalid, unconstitutional, or otherwise ineffective or (b) amendments to the law by legislation.

MISCELLANEOUS

Additional Programs

Cigna may from time to time offer, or arrange for various entities to offer, discounts or other consideration to MEMBERS for the purpose of promoting the general health and well-being of Members. Contact Cigna Member Services for a list of currently available programs, participating businesses, and other details regarding such arrangements. These programs, which do not constitute benefits under this Agreement, may include discounts on the following types of services:

- Health Club/Gym Memberships
- Tai Chi Classes

- Weight Loss Programs
- Alternative Care, including Massage Therapy
- Health Food Stores
- Over the Counter Medications
- Vision Products and Services
- Hearing Aids and Services
- Wellness Classes - Selected classes may be offered to Our Members for a copayment at participating Cigna Health Care Centers.
- Cigna HealthCare Healthy Babies Program®

These programs are provided for the benefit of Cigna HealthCare Members, and are not an endorsement of the services or vendors listed. Discounts are subject to change or elimination upon sixty (60) days' prior notice.

Relationships

The Subscriber enters into the Agreement on behalf of the eligible individuals enrolling under the Agreement. Acceptance of the Agreement by the Subscriber is acceptance by and binding upon those who enroll as Subscribers and Dependents.

The relationship between Cigna and Participating Physicians who are not employees of Cigna are independent contractor relationships. Such physicians, hospitals, and Physicians are not agents or employees of Cigna; and Cigna and its employees are not agents or employees of such physicians, hospitals or Physicians.

Notice

With respect to this Agreement, means written notice which shall be hand-delivered or mailed through the United States Postal Service, postage prepaid, addressed to the latest address furnished to Cigna by Subscriber or by the Member.

Fraud:

If the Subscriber or Dependent has committed, or allowed someone else to commit, any fraud in connection with this Agreement, then any and all coverage under this Agreement shall be void and of no legal force or effect. For purposes of this provision, fraud and/or deception includes, in addition to other intentional misrepresentation, the concealment or intentional misrepresentation of the direct or indirect source of Your Premium or other cost-sharing obligations under this Agreement.

Entire Agreement

This Agreement constitutes the entire agreement between the parties. The Agreement supersedes any other prior Agreements between the parties. No agent or other person, except an officer of Cigna, has authority to waive any conditions or restrictions of the Agreement; extend the time for making payment; or bind Cigna by making any promise or representation, or by giving or receiving any information, except as otherwise provided under applicable law. No change in the Agreement shall be valid unless stated in an Amendment attached hereto signed by an officer of Cigna.

This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or waive any of its provisions.

Severability

If any term, provision, covenant or condition of the Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated.

No Implied Waiver

Failure by Cigna on one or more occasions to avail itself of a right conferred by the Agreement shall in no event be construed as a waiver of Cigna's right to enforce said right in the future.

Records

Cigna keeps records of all Members, but shall not be liable for any obligation dependent upon information from the Subscriber prior to its receipt in a form satisfactory to Cigna. Incorrect information furnished by the Subscriber may be corrected, if Cigna shall not have acted to its prejudice by relying on it. All records of the Subscriber and Cigna which have a bearing on coverage of Members hereunder shall be open for review by Members at any reasonable time.

Clerical Error

No clerical error on the part of Cigna shall operate to defeat any of the rights, privileges or benefits of any Member.

Incontestability

All statements made by the Subscriber on the application for enrollment are considered representations and not warranties. The statements are considered truthful and made to the best of the Subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel or non-renew a Member's coverage or reduce benefits under this Agreement unless

- It is in a written enrollment application signed by the Subscriber; and
- A signed copy of the enrollment application is or has been furnished to the Subscriber or the Subscriber's personal representative.

An individual Agreement may only be contested because of fraud or intentional misrepresentation of material fact made on the application for enrollment.

Administrative Policies Relating to This Agreement

Cigna may adopt reasonable policies, procedures, rules and interpretations which promote orderly administration of this Agreement.

Access to Information Relating to Physician Services

Cigna is entitled to receive from any Physician who renders service to a Member all information reasonably necessary to fulfill the terms of this Agreement. Subject to applicable confidentiality requirements, Members hereby authorize any Physician rendering service hereunder to disclose all facts pertaining to such care and treatment; also, to render reports pertaining to such care or physical condition and permit copying of records by Cigna.

Premium Payments ONLY by Subscriber or Acceptable Third Party Payor

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.

Access to Information Relating to Provider Services

Cigna is entitled to receive from any Provider who renders service to a Member all information reasonably necessary to fulfill the terms of this Agreement. Subject to applicable confidentiality requirements, each Member authorizes any Provider rendering service to disclose all facts pertaining to such service, to render reports pertaining to such services or the Member's physical condition and to permit copying of records by Cigna.

Agreement Binding on Members

By electing health care coverage pursuant to this Agreement, or accepting services or benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions herein. However, this Agreement shall be subject to amendment, modification or termination in accordance with any provisions hereof, without the consent or concurrence of the Members.

Class Action Waiver: Without limiting the applicability of A.R.S. § 20-3151 et seq., under this

provision of this Agreement, You (including any legal representative acting on Your behalf) expressly waive the right to participate, as a plaintiff or class member, in any purported class, collective, representative, multiple plaintiff or similar proceeding ("Class Action") which names or purports to name Cigna and any of its operating subsidiaries or affiliated entities as defendants. Except as provided by State law reference; under this provision of the Agreement You expressly waive the ability to maintain a Class Action in any forum.

Applications, Statements, etc.

Members or applicants for membership shall complete and submit to Cigna such applications or other forms or statements as Cigna may reasonably request. Members warrant that all information shown in such applications, forms or statements shall be true, correct and complete. All rights to benefits hereunder are subject to the condition that all such information shall be true, correct and complete.

Successors and Assigns

This Agreement shall be binding upon and shall inure to the benefit of the Successors and Assigns of Cigna, but shall not be assignable by any Member.

Identification Card

Cards issued by Cigna to Members pursuant to this Agreement are for identification only. Possession confers no right to services or other benefits under this Agreement. To be entitled to such services or benefits the holder must, in fact, be a Member on whose behalf all Charges and Member payments under this Agreement have actually been paid. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the terms of this Agreement, or who permits another person to receive such services or benefits, shall be chargeable therefor at Prevailing Rates. If any Member permits the use of his or her Cigna identification card by any other person, such card may be retained by Cigna, and all rights of such Member hereunder may be terminated according to the "Specific Causes for Ineligibility" Section.

SCHEDULE OF BENEFITS

The following is the Cigna Connect 0-4 Benefit Schedule, including medical, prescription drugs and pediatric vision benefits. The Agreement sets forth, in more detail, the rights and obligations of both You and Your Family Member(s) and the Agreement. It is, therefore, important that all Members **READ THE ENTIRE Agreement CAREFULLY!**

Services for Out-of-Network providers are not covered except for initial care to treat and stabilize an Emergency Medical Condition. SERVICES FROM NON-PARTICIPATING PROVIDERS ARE NOT AVAILABLE EXCEPT AS DESCRIBED IN THE "EMERGENCY SERVICES" PROVISION OF THE "SERVICES AND BENEFITS" SECTION OR WITH THE PRIOR APPROVAL OF THE CIGNA MEDICAL DIRECTOR.

Members are entitled to receive the services and benefits set forth in this Benefit Schedule, subject to payment of Copayments, Percentage Copayment and any applicable Deductible as specified in the Benefit Schedule, and subject to the conditions, limitations and exclusions of this Agreement.

Services that require Prior Authorization include, but are not limited to, inpatient Hospital services, inpatient services at any Other Participating Healthcare Facility, outpatient facility services, advanced radiological imaging, non-emergency ambulance, and Transplant Services. Prior authorization for non-emergency ambulance services may be obtained from a Participating Provider that is treating the Member.

Prior Authorization requirements for Prescription Drugs are detailed in the "Prescription Drugs" section of the Agreement.

BENEFIT INFORMATION **Note:** **Covered Services are subject to applicable Deductible unless specifically waived.**	**IN-NETWORK PROVIDER** **(Based on the Negotiated Rate for Covered Expenses)** **YOU PAY:**
Medical Benefits	
Deductible **Individual** **Family**	 $0 $0
Out-of-Pocket Maximum **Individual** **Family**	 $2,600 $5,200 The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties and Policy Maximums.
Coinsurance	You and Your Family Members pay 5% of Charges.

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
Prior Authorization Program **Prior Authorization – Inpatient Services** **Prior Authorization – Outpatient Services** **NOTE:** Please refer to the section on Prior Authorization of inpatient and outpatient services above for more information in Your Plan. 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 Benefits Details".	Your Participating Provider must obtain approval for inpatient admissions; or Your Provider may be assessed a penalty for non-compliance. Your Participating Provider must obtain approval for certain outpatient procedures and services; or Your Provider may be assessed a penalty for non-compliance.
Preventive Care Services Please refer to "Preventive Care-Periodic Health Examinations" section of the Plan for additional details.	0%
Newborn/Infant Hearing Screening	0%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
Pediatric Vision Care Performed by an Ophthalmologist or Optometrist for a Member, through the end of the month in which the member turns 19 years of age. Please be aware that the Pediatric Vision network is different than the network of your medical benefits.	
Comprehensive Eye Exam *Limited to one exam per year*	0%
Eyeglasses for Children *Limited to one pair per year*	
Pediatric Frames	0%
Single Vision Lenses,	0%
Lined Bifocal Lenses,	0%
Lined Trifocal or Standard Progressive Lenses,	0%
Lenticular	0%
Contact Lenses for Children *Annual limits apply*	
Elective	0% per pair
Therapeutic	0% per pair
Low Vision Services *Annual limits apply*	0% per pair

BENEFIT INFORMATION **Note:** **Covered Services are subject to applicable Deductible unless specifically waived.**	**IN-NETWORK PROVIDER** **(Based on the Negotiated Rate for Covered Expenses)** **YOU PAY:**
Physician Services **Office Visit** **Primary Care Physician (PCP)** **Specialist Physician including consultant, referral and second opinion services)** **NOTE:** if a Copayment applies for OB/GYN visits, the level of Copayment You pay will depend on how Your doctor is listed in the provider directory	 $0 for visits 1 and 2 You pay 5% for additional visits 5%
Cigna Telehealth Connection Services ▪ Virtual visit with a **Cigna Telehealth 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. ▪ **Covered Services from any other Participating Physician delivered by Virtual means** (Not limited to minor acute medical conditions)	 $0 Same benefit as when service provided in person
Physician Services, continued **Surgery in Physician's office** **Outpatient Professional Fees for Surgery (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy)** **Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy** **In-hospital visits** **Allergy testing and treatment/injections**	 5% 5% 5% 5% 5%

BENEFIT INFORMATION **Note:** **Covered Services are subject to applicable Deductible unless specifically waived.**	**IN-NETWORK PROVIDER** **(Based on the Negotiated Rate for Covered Expenses)** **YOU PAY:**
Hospital Services **Inpatient Hospital Services** Facility Charges Professional Charges	 5% 5%
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	5%
Laboratory, Diagnostic Therapeutic Radiology and Advanced Imaging Services **Facility and interpretation charges** Physician's Office Free-standing/Independent lab or x-ray facility Outpatient hospital lab or x-ray MRIs, MRAs, CAT Scans, PET Scans, ECT; Beams	 5% 5% 5% 5%
Rehabilitative Services Maximum of 60 visits per Member, per calendar year for Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac & Pulmonary Rehabilitation therapies combined. Maximum does not apply to services for treatment of Autism Spectrum Disorders Chiropractic Treatment 20 self-referral visits available, unlimited Maximum	5% 5%
Habilitative Services Maximum of 60 visits per Member, per calendar year for Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac & Pulmonary Rehabilitation therapies combined. Maximums for Rehabilitative Services do not apply to Habilitative services. **Note:** Maximum does not apply to services for treatment of Autism Spectrum	5%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
Hearing Aids Maximum 1 hearing aid per ear, per Calendar Year	5%
Hearing Exam Maximum of 1 visit per Member, per Calendar Year	5%
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD) / Orthognathic Surgery	Copayment or Coinsurance applies for specific benefit provided
Routine Foot Care (for treatment of diabetes and peripheral vascular disease)	5%
Bariatric Surgery	5%
Medical Foods to treat inherited metabolic disorders	50%
Amino Acid Based formula to treat Eosinophilic Gastrointestinal Disorder	25%
Family Planning **Womens' Contraceptive Services and Sterilization** **Male Sterilization**	0% Copayment or Coinsurance applies for specific benefit provided
Breastfeeding equipment, supplies, and counseling	0%
Maternity (Pregnancy and Delivery) /Complications of Pregnancy **Initial Office Visit to confirm pregnancy** and subsequent prenatal visits billed separately from the "global" fee **Prenatal services, Postnatal and Delivery** (billed as "global" fee)	PCP or Specialist Office visit benefit applies 5%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
Hospital Delivery charges	5%
Prenatal testing or treatment billed separately from "global" fee	5%
Postnatal visit or treatment billed separately from "global" fee	PCP or Specialist Office visit benefit applies
Dialysis	
Inpatient	Inpatient Hospital Services benefit applies
Outpatient	5%
Autism Spectrum Disorders	
Diagnosis of Autism Spectrum Disorder	
Office Visit	PCP or Specialist Office Visit benefit applies
Diagnostic testing	5%
Treatment of Autism Spectrum Disorder Please refer to "Autism Spectrum Disorder" section of the Plan for specific details and limitations.	Benefit applies according to type of service provided
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities. Unlimited Maximum	5%
Home Health Services Maximum of 42 visits per Member, per Calendar Year.	0%
External Prosthetic Appliances	5%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
Durable Medical Equipment	5%
Hospice	
Inpatient	Inpatient Hospital Services benefit applies
Outpatient	5%
Mental, Emotional, Functional Nervous Disorders and Serious Mental Illness	
Inpatient (Includes Acute and Residential Treatment)	Inpatient Hospital Services benefit applies
Outpatient (Includes individual, group, intensive outpatient and partial hospitalization)	
Office Visit	5%
All other outpatient services	5%
Substance Use Disorder	
Inpatient Detoxification/Rehabilitation (Includes Acute and Residential Treatment)	Inpatient Hospital Services benefit applies
Outpatient (Includes individual, group, intensive outpatient and partial hospitalization)	
Office Visit	5%
All other outpatient services	5%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
Organ and Tissue Transplants- (Note: Ventricular assist devices and advanced cellular therapy are **only** covered at a LifeSOURCE facility. 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 Maximum $10,000 per Member, per transplant. **Non-LifeSOURCE Participating Facility specifically contracted to perform Transplant Services** **Participating Facility NOT specifically contracted to perform Transplant Services**	0% 5% Not Covered
Advanced Cellular Therapy Services Cigna LifeSOURCE Transplant Network® Facility Non-LifeSOURCE Facility (Participating or Non-Participating)	0% Not covered
Ventricular Assist Device Services Cigna LifeSOURCE Transplant Network® Facility Non-LifeSOURCE Facility (Participating or Non-Participating)	0% Not covered
Infusion and Injectable Specialty Prescription Medications and related services or supplies	5%

Emergency Services ***Note: This Agreement covers Emergency Services from Participating and Non-Participating Providers as shown:***	***What You Pay*** For **Participating Providers** based on the Negotiated Rate for Covered Expenses	***What You Pay*** For **Non-Participating Providers** based on the Maximum Reimbursable Charge for Covered Expenses
Emergency Services – • **Hospital Emergency Room** **Emergency Medical Condition**	$500 Copayment per visit	$50 Copayment per visit for an Emergency Medical Condition, otherwise You pay 100%
Non-Emergency Medical Condition	Not Covered	Not Covered
• **Urgent Care Services**	$25 Copayment per visit	In-network Cost Share for an Emergency Medical Condition, otherwise You pay 100%
• **Ambulance Services** Note: coverage for Medically Necessary transport to and from the nearest facility capable of handling an Emergency Medical Condition. **Emergency Transport**	5% for air, ground and water emergency transport	In-network Cost Share for an Emergency Medical Condition, otherwise You pay 100%
Inpatient Hospital Services (for emergency admission to an acute care Hospital) • **Hospital Facility Charges**	5%	In-Network Cost Share until transferable to an In-Network Hospital; if not transferred then You pay 100%
• **Professional Services**	5%	In-Network Cost Share until transferable to an In-Network Hospital; if not transferred then You pay 100%

PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	

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 the Benefit Schedule. Drugs on the Narrow Therapeutic Index (NTI) are excluded.

	Cigna Retail Pharmacy Drug Program **YOU PAY PER PRESCRIPTION OR REFILL:**	**Cigna Home Delivery Pharmacy Drug Program** **YOU PAY PER PRESCRIPTION OR REFILL:**
Tier 1: This tier typically includes preferred Generic Drugs. These drugs have the same strength, and active ingredients as Brand Name Drugs, but often cost much less. Preferred Generic Drugs are covered at the plan's lowest Cost Share.	$0 Copayment 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.	$0 Copayment per Prescription or refill Up to a 90 day maximum supply
Tier 2: This tier typically includes most Generic Drugs and some low cost Brand Name Drugs. Generic Drugs have the same strength and active ingredients as Brand Name Drugs, but often cost much less.	$10 Copayment 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 per Prescription or refill Up to a 90 day maximum supply
Tier 3: This tier typically includes preferred Brand Name Drugs and some high cost Generic Drugs.	$30 Copayment 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.	$90 Copayment per Prescription or refill Up to a 90 day maximum supply
Tier 4: This tier typically includes non-preferred Brand Name Drugs and some high cost Generic Drugs.	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 Up to a 90 day maximum supply

PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY YOU PAY AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	CIGNA HOME DELIVERY PHARMACY YOU PAY AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED
Tier 5: This tier typically includes Specialty Medications and high cost Generic and Brand Name Drugs.	40% per Prescription or refill 30 day supply at any Participating Pharmacy or Up to a 30 day supply at a 90 Day Retail Pharmacy.	30% per Prescription or refill Up to a 30 day maximum supply
Preventive Drugs regardless of Tier Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive including but not limited to: ▪ women's contraceptives that are Prescribed by a Physician and Generic, or Brand Name with no Generic alternative available; and ▪ smoking cessation products	0% 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% per Prescription or refill Up to a 90 day maximum supply

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 **See the "Covered Benefits" section for details**	**In-Network**
Pediatric Vision Care Performed by an Ophthalmologist or Optometrist for a Member, through the end of the month in which the Member turns 19 years of age. Please be aware that the Pediatric Vision network is different than the network of your medical benefits.	
Comprehensive Eye Exam *Limited to one exam per year*	You Pay 0%, deductible waived
Eyeglasses and Lenses for Children *Limited to one pair per year*	
Pediatric Frames	You Pay 0%, deductible waived
Single Vision Lenses,	You Pay 0%, deductible waived
Lined Bifocal Lenses,	You Pay 0%, deductible waived
Lined Trifocal or Standard Progressive Lenses,	You Pay 0%, deductible waived
Lenticular	You Pay 0%, deductible waived
Contact Lenses for Children *Annual limits apply*	
Elective	You Pay 0% per pair, deductible waived
Therapeutic	You Pay 0% per pair, deductible waived
Low Vision Services *Annual limits apply*	You Pay 0% per pair, deductible waived

Definitions

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

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

Pediatric Vision Benefits

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

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

Benefits will apply until the end of the month in which this limiting age is reached.

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

Covered Benefits

In-Network Covered Benefits for Member's, through the end of the month in which the Member turns 19 years of age include:

- Examinations – One vision and eye health evaluation per year by an Optometrist or an Ophthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.

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

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

- Frames – One frame for prescription lenses per year from Pediatric Frame Collection. Only frames in the Pediatric frame Collection are covered at 100%. Non-Collection Frames: 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 professional services.

- Therapeutic Contact Lenses are covered for a one year supply, regardless of the contact lens type, including professional services, in lieu of frame and lenses. Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by Your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction are not covered.

- Low Vision Coverage: Supplemental professional low vision services and aids are covered in full once every 12 months for a Member 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 Member 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 in excess of the usual and customary charge for the Service or Material.
- Charges incurred after the Agreement ends or the Insured's coverage under the Agreement ends, except as stated in the Agreement.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "Covered Benefits" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lens treatments, "add ons", or lens coatings not otherwise listed in "Covered Benefits." within this section, above.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.

- For or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
- Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.
- 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 Member 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.

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